MASSACHUSETTS SCHOOL OF PROFESSIONAL PSYCHOLOGY

PREVENTION AND REDUCTION OF RESTRAINT AND SECLUSION IN PUBLIC SCHOOLS: A COMPREHENSIVE APPROACH

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> I dreamed of anxiously looking for someone else's dog that I was taking care of and that had run away. Suddenly someone who has been difficult in my life showed me the way to find him! An unknown, yet hostile person was running with my cat (by then not a dog anymore—interesting as I do not like cats) and when I asked for my cat, that person said, "The spiked dog collar is mine" and I bravely and assertively said, "But the cat is mine!" Qué será, será? (Macias-Smith, 2012)

This is the end and the beginning of an anticipated yet unanticipated moment in my life and I am grateful for the journey that I took and wonder so much about the way ahead. I am going full circle from a young psychologist who emigrated from Colombia in 1991 to becoming a mature psychologist in the United States 21 years later!

I may just go with first names as they mean so much to me, I know who they are and they know who I am, and this is enough for the parties! In this section I would like to excuse the credentials; while respecting how dutifully earned, I also want to respect the dignity of all without them.

To Colombia, my patria, and to my parents, Maria Luisa and Luis Carlos, my grandmother, Maria, and my sister, Nohorita, all blessings beyond this earth. To my siblings Arturo, Luisa, Helena, Cecilia, Miguel, Luz-Marina, Antonio-Jose, Luis-Carlos, Alvaro and Juan-Pablo, my special twenty four nephews and nieces, my extended family: all wonders of my childhood that sustain me to this day and all our relatives left behind geographically but in my heart daily, if I try to name all in my extended family, we will never finish—I guarantee it!

To my husband, Greg, and my children, Philip Arturo, Sabrina Margarita and

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A COMPREHENSIVE APPROACH

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Abstract

This doctoral project explored the research question: *will a comprehensive guidebook, which aims to reduce the use of restraint and seclusion in public schools by providing education and skill-building strategies, have a positive impact on the teachers, students and stakeholders involved?* A guidebook was developed for teachers that supported developing their skills towards reduction and prevention of physical restraint and seclusion of children that attend public schools.

Ten teachers were interviewed and an assessment of the guidebook's utility and satisfaction was made. It used a formative evaluation, single group non-experimental design to assess the guidebook's utility and satisfaction conducive to strategies that support R/S reduction in schools. Recommendations and suggestions were collected conducive to future improvement of the created guidebook.

Table of Contents

CHAPTER ONE

INTRODUCTION

I bring to this doctoral project the experience of a parent who has had to become an educated consumer of restraints. I am the mother of a child who was restrained numerous times from the age of five by school personnel. Despite my personal confusion and anguish over my son's suffering, I felt unable to challenge the practice of restraint use in school because I was initially not aware of restraint use, the controversy surrounding its use, its impact on all those involved and the sometimes dire effects of restraint use on the child. I was also not aware that there were feasible and effective alternative approaches to resolving disturbing behavior in the classroom, which could not only eliminate the use of restraints, but also foster an increased sense of wellbeing in the child and lead to improved classroom morale. This doctoral project provides accurate information about the effects of restraint use and appropriate alternatives, so that children, their parents and their teachers no longer find themselves in the position of unwittingly and unnecessarily fostering institutional violence in the classroom. Physical restraint and seclusion (R/S) in public school settings are detrimental to the health and mental health of children and people around them: "There are several mechanisms of injury, death and physical and psychological trauma to both staff and children associated with the use of R&S" (LeBel, Nunno, Mohr, O'Halloran, 2012, p. 78). Public schools are institutions that pass on learning and socialization to our country's children. In the United States, children under the age of 18 have the right to receive an education and, by law, are required to attend school (National Center for Education Education Statistics, n.d.). If a child has a disability, it is his or her right to attend public school until the age of 22

(National Dissemination Center for Children with Disabilities, 2011). It is our government's responsibility to provide physical space and the necessary materials to foster learning and socialization (U.S. Department of Education [USDOE], 2010). A clear expectation for public schools is the establishment of an administration that will support staff's needs and provide them with the necessary resources to foster skills and knowledge in the children they teach (USDOE, 2010). Teachers and additional education professionals are expected to efficiently deliver sequential instruction. An important assumption regarding the operation of our nation's public schools is that they provide a safe environment for all children, whether or not they have a disability, in which their learning may be fostered. Research indicates that R/S are harmful in mental health settings (Mohr & Anderson, 2001).

This generalization may also be applied to the use of R/S in schools. Fifteen years ago, Czumbil and Hyman argued that the number of abuses at schools were underrepresented and that corporal punishment in schools was harmful (Czumbil & Hyman, 1997), these statements have been reiterated more recently in research done by the American Civil Liberties Union/Human Rights Watch (ACLU/HRW) in their *Impairing Education: Corporal Punishment of Students with Disabilities in U.S. Public Schools*' document (ACLU/HRW, 2009).

This doctoral project will focus on R/S. Both physical restraint and 'restraint by seclusion' are forms of restraint. The term *restraint* refers to physical restraint and restraint by seclusion. The Massachusetts Department of Elementary and Secondary Education defines seclusion as a procedure that involves placement in a limited space or location (Massachusetts Department of Elementary and Secondary Education, n.d.). R/S

are used in public schools across the United States. Physical restraint is a method by which one or more persons restrict another person's freedom of movement, physical activity or normal access to his/her body (Peterson, 2010).

R/S have consequences, as shown by an extensive body of literature. R/S can injure and/or kill children, and the use of R/S affects not just the child, but all the people involved (National Disabilities Rights Network, 2009). The organization TASH[1], an international leader in disability advocacy, investigated available literature on the use of R/S. They found that there was insufficient evidence supporting the idea that R/S is a safe means of teaching children appropriate self-directed and sustainable behavior (TASH, n.d.). On the contrary, their analysis of R/S literature demonstrates that R/S offers no therapeutic value, and can increase problematic behavior and decrease positive, pro-social behavior. Additionally, R/S use in school settings may result in injury or death.

This researcher's operating assumptions are that anyone who experiences R/S in a public school setting will develop psychological distress as a result of the R/S and that the development of psychological pain associated with being exposed to R/S procedures is not limited to the student. Other people affected are classmates, teachers, restrainer(s), other witnesses and parents.

Schools can use additional options that can improve the climate and support strategies to reduce R/S, such as improving the classroom environment, supporting teachers' knowledge of classroom management, and using positive supports that will

[1] The official name of the organization has gone through several changes since its inception more than 35 years ago. It was first called the American Association for the Education of the Severely and Profoundly Handicapped. In 1980, the name was changed to The Association for the Severely Handicapped, reflecting the organization's broader mission. Again in 1983, the name was changed to The Association for Persons with Severe Handicaps, although the acronym TASH was widely used. In 1995, the Board of Directors voted to discontinue the full name of the organization as it did not reflect current values. The acronym, TASH, was maintained due to its wide recognition.

increase prosocial behaviors. There are other alterative behavioral management options available for use in the classroom:

> With creativity, a student can go beyond available alternatives to construct new options for their lives. When we encourage children to imagine, to dream and fantasize and take liberty with reality, we teach them essential skills in adapting to intense change. In an atmosphere of isolation, anxiety and fear creativity is stifled. If, then, classroom climate matters, for both intellectual and emotional well-being, it is necessary to identify those practices that result in impersonalization, distrust, humiliation, fear, and discouragement for both teachers and students. (Butchart and McEwan, 1998, p. 246)

Historical and Current Trends

One of the first uses of restraint to manage behavior amongst non-criminal populations was in the mental health system. Restraint was initially labeled by the psychiatric community as an intervention, and it was designed along with seclusion to protect both patients and staff. However, the contemporary opinion is that restraint and seclusion are neither therapeutic nor safe, especially when used with children (Mohr, LeBel, O'Halloran & Preustch, 2010). Research indicates that R/S is a commonly used procedure that has been found to be problematic, involving high risk, dangerous, and lacking evidence for effectiveness (Mohr, Petti & Mohr, 2003). Moreover, they are based on a number of refutable and often unexamined assumptions (Mohr & Anderson, 2001).

R/S became a highly contentious issue in 1998 following the publication of a series of investigative reports called "Deadly Restraints" in the *Hartford Courant* (Weiss, Altimari, Blint and Megan, 1998). The investigative reports highlighted the issues of R/S and connected them with injuries, death and impaired physical and psychological health for children and adults (LeBel et al., 2012). Research focused heavily on the use of R/S in psychiatric and residential placements; however, there was also documentation of

adverse effects of restraint on children in schools. In order to follow up on the issues specifically related to R/S in schools, the Committee on Education and Labor asked the United States Government Accountability Office (GAO) to:

> (1) provide an overview of seclusions and restraint laws applicable to children in public and private schools, (2) verify whether allegations of student death and abuse from the use of these methods are widespread, and (3) examine the facts and circumstances surrounding cases where a student died or suffered abuse as a result of being secluded or restrained. (2009, p. 2)

The GAO responded to this request by searching federal and state laws on R/S in public and private schools and reviewing records from the past 20 years related to allegations of death, injury, and abuse of students as a consequence of R/S. They selected 10 cases in nine different states for investigation. Of the cases they examined, they found that R/S was typically used with children with disabilities and often in situations in which they were not physically aggressive. Additionally, R/S was often used without parental consent. The report found that restraint, as performed, often blocked air to the lungs and was identified as potentially deadly. Furthermore, they found that teachers and staff who performed the restraint were often not trained regarding the use of R/S.

The National Association of State Mental Health Program Directors (NASMHPD) has stated that R/S thwart the development and mastery of essential social skills, impede trust and learning, model violent behavior by adults and essentially teach youth to manage problems with physical aggression (NASMHPD, 2009). In response, NASMHPD created a curriculum based on six core strategies that focus on the prevention of R/S (Huckshorn, 2005). The goal of the curriculum is to change organizational culture and to eliminate violence in care settings. These strategies advocate: (1) leadership to create organizational change; (2) the use of prevention tools, individual crisis prevention

plans and sensory interventions; (3) the use of data to inform practice; (4) the development and support of a workforce; (5) the inclusions of consumers (i.e., youth and families) in the process and; (6) the use of debriefing methods to prevent reoccurrence if R/S occurs.

TASH (2009) reported that the use of restraining devices, blindfolds, visual screens, and white noise helmets resulted in sensory deprivation. They argue that the use of these techniques disrupts a child's basic emotional wellbeing and sense of safety. Restraint and its associated devices prevent exercise, peer interactions, and other physical activities. TASH argues that restraint results in the long-term loss of the normal freedoms and pleasures of childhood and, thus, should be considered aversive. TASH has as its mission to eliminate the physical and social obstacles that prevent equality and reduce diversity, and aims to increase quality of life for children and adults with disabilities.

In 2004, TASH convened the Alliance for the Prevention of Restraint, Aversive Interventions and Seclusion (APRAIS)[2]. APRAIS is made up of twenty-two organizations. It acts to protect children with disabilities and challenging behaviors from abuse in schools, treatment programs and residential facilities. In May, 2009, APRAIS worked with Congress to introduce legislation that would end the use of these practices as planned interventions in public schools. In 2012, APRAIS is still fighting to get this legislation through the U.S. House of Representatives and Senate.

Under H.R. 1381 and S. 2020, R/S can only be used in an emergency. However in many states R/S is included on IEPs, even over the objection of parents. If R/S are interventions included in the IEP, they may become part of the toolkit that schools use to

[2] See http://tash.org/advocacy-issues/restraint-and-seclusion-aprais/

manage behavior, perhaps neglecting the possibility of using positive behavioral interventions, as IDEA's requires (APRAIS, 2010).

To follow the national interest and concern related to the consequences of restraint and seclusion use on children and the fostering of a safe environment, states are reviewing policies and regulations. For example, Maine is attempting to change existing regulations in order to allow physical R/S only as an emergency intervention when the behavior of a student presents an imminent risk of injury or harm to the student and others. They are promoting use of a collaborative approach that includes definitions, behavioral plans, parent involvement, the reporting of policies, monitoring, documentation, complaint process and staff training to ensure students have safer environments for learning.

In the early 2000s, there was no federal law to prevent or reduce R/S use with school children, and, in fact, there was no federal action at all. Furthermore, almost half of the states had no laws or policies, and existing state laws and policies varied greatly and were often inadequate. In January, 2009, the National Disability Rights Network released a report entitled *School is Not Supposed to Hurt* (National Disabilities Rights Network [NDRN], 2009). The report revealed that students in every region of the country were being injured, and even killed, by being abusively restrained and secluded in school settings. It uncovered that R/S was often misused to force a student to stay on task or as a disciplinary measure, despite the consensus that R/S is not therapeutic (NDRN, 2009; Jones 2003; LeBel; 2003).

Despite years of advocacy from the mental health community that went to great lengths to issue positions, parameters and regulations to protect children from the use of

restraint, this knowledge is not being adapted by schools, and the local educational agencies have not been doing enough to properly address policies and regulations that protect children from those practices. One strategy that will help is to learn from the mental health system, as mental health practitioners have paid significant attention to reducing R/S. Schools can learn from these initiatives. Given the circumstances of restraint-use in schools today, it is important to acknowledge that the education and school literature is notably quiet on the use of restraint in schools (Ryan & Peterson, 2004).

Definition of Terms

It is important to acknowledge that the terms 'corporal punishment' and 'physical restraint' are used in different ways depending on the author. Physical restraint is a form of corporal punishment. Physical restraint aims to reduce aggression and to de-escalate, while corporal punishment aims to inflict pain to reduce unwanted behaviors. According to the United Nations Committee on Rights of the Child (2006), physical restraint is a form of corporal punishment. However, both forms model aggression. Another concern is that both terms can be called techniques, methods of discipline, behavior management tools and/or therapeutic tools. Researchers such as Hyman, Huesman, Walder, and Monroe (as cited in Eron, 1996, p. 821) agree that corporal punishment, "is ineffective as a disciplinary tool and often has serious psychological and physical consequences" (p. 821). Additional terms in this doctoral project related to corporal punishment and restraint may seem ambiguous. In fact, there is considerable ambiguity concerning definitions of the terms. For example, time out, time away, exclusion, chair time, isolation, quiet isolation and quiet space are forms of acceptable seclusion in school.

Also, the terms of the seclusion, including its duration, can be unclear to parents. Finally, parents may not understand terms such as 'seclusion' at all, and may not know what specific practice to which this term is referring.

Research Question

The present study explores the research question: *will a comprehensive guidebook, which aims to reduce the use of restraint and seclusion in public schools by providing education and skill-building strategies, have a positive impact on the teachers, students and stakeholders involved?* For this research, the specific guidebook that will be developed is for teachers; further research will focus on other stakeholders. It is contended that such a guidebook will provide psychoeducation and strategies that will prove useful for diminishing the use of R/S in public schools. The guidebook will include a multidisciplinary approach, which would make use of a range of cost-effective resources. There is some anecdotal evidence that a multi-disciplinary plan that includes occupational therapy, mental health, social pragmatics, a stronger identification system and a solid referral system greatly improve prevention strategies aimed at diminishing the use of restraint. In school settings, positive behavioral interventions, which are systemic in nature, promote authentic change (American Civil Liberties Union/Human Rights Watch [ACLU/HRW], 2009, p. 54). A less stressful environment where restraint use will be reduced or eliminated will benefit all students, teachers and stakeholders because the use of restraint adds unnecessary strain.

An important aim of the development of a guidebook for R/S prevention and reduction is to promote education and communication among the different stakeholders involved. It is important to address different stakeholders because collaborative efforts in

school systems lead towards a more effective comprehensive approach. This study will be a demonstration project. The guidebook will consist of multiple strategies intended to provide a framework for working with multiple stakeholders. To meet the need for a set of protocols for how to reduce R/S, the guidebook will foster a greater understanding of prevention efforts. It will employ principles conducive to promoting adult learning, and it will include alternative strategies such as those used in mental health and occupational therapy settings. The guidebook will also suggest changes that can be made to policies and procedures with the aim of creating safer schools. It is hoped that an outcome from reading the guidebook will be that R/S will be the exception and not the norm, and that there will be a serious effort to prevent restraint from happening in the first place. Such schools will foster a climate that promotes socialization and learning as the pillars of education.

In order to evaluate the effectiveness of this comprehensive approach to R/S, an electronic version of the guidebook will be distributed to teachers and an interview will take place. Using a formative evaluation, single group non-experimental design will be helpful to assess if the guidebook is useful, clear and conducive to strategies that support R/S reduction.

This researcher's bias throughout this research comes from her own experience as the mother of a child that had been restrained in public schools in Massachusetts. Additionally, the author had also been employed as a technical assistance provider at a national level in the area of violence prevention in public school districts. In her eight years of training educators and mental health providers, the issue of restraint did not come up once as an issue. It is for this reason that the author made the choice to design

such a guidebook and receive feedback on its usefulness. The author feels that she can be adequately objective in producing an effective guidebook as a tool for stakeholders without her personal experience clouding or skewing the results in a significant way.

The fact that injuries and deaths have resulted from the use of R/S in schools is ample reason for the author's decision to focus on this topic. Finally, this topic is relevant to the field of psychology. Multiple agencies have made significant efforts towards prevention in this area. Several states have existing models of R/S prevention, including Massachusetts, Arizona, Pennsylvania and Wisconsin. Some school-based efforts will be highlighted from Pennsylvania, Texas and Arizona. This is not an exhaustive list. The Doctoral project will explore available literature and will describe the effects of several state interventions designed to reduce R/S in schools.

CHAPTER TWO

LITERATURE REVIEW

> Julio, at 14 years of age described different restraint methods that were used on him, such as handcuffs in juvenile justice programs, safety coats, papoose boards, leather wrist and ankle restraints in mental health settings, and physical restraints in public and residential schools. "If my foster parents did to me at home the stuff staff did in my old programs, they'd be talking to a judge," he said. "I know they're supposed to be used like in an emergency or something, but that's not what's going down. You can get restrained for just looking the wrong way at someone, dissin' a teacher, or saying no. One program I was in, this dude would start his shift and say, 'I feel like breakin' a few heads tonight'.... That's scary!" (Caldwell & LeBel, 2010, para. 2)

This literature review will begin with a discussion of definitions of R/S. It will then review the history of corporal punishment in schools, of which the use of R/S has been defined as one form. Legal issues concerning the use of R/S will be discussed. Also relevant is debate around R/S use involving specific populations, including children, people with disabilities, people with mental illness and the elderly, because national efforts to effectively support this population were seminal to the development of concern more generally about R/S use. Procedures and outcomes of the use of R/S in schools will be examined. Finally, the literature review will consider alternatives to R/S use.

Definitions of Restraint

This section provides a definition of different types of restraint for the purposes of the discussion of restraint use. In addition, the topic of how restraint is defined is a critical one for improving safety when restraint is used. It has been noted that parents can be confused by what is defined as 'seclusion' and the conditions in which seclusion may take place. Seclusion is one kind of containment. At a more general level, it is important to be aware of how seclusion itself is defined and what other kinds of restraints there are.

Definitions of restraint are important because different forms of restraint have been shown to have different consequences. Research has established that some kinds of restraint, such as prone restraint, are more dangerous (and even deadly) to children than others. One of the author's operating assumptions is that any kind of restraint is detrimental to the wellbeing of the child and people around him. However, it is important to inform stakeholders of the specific practices of the restraint and what kind of restraint is being implemented. It has been established that the multiple terms that are used to explain restraint in schools ('hold,' 'hands on,' 'escorting') do not reflect the seriousness of the restraint being implemented; school personnel who are informing a parent their child was put in a 'hold' may actually be talking about an incident in which a child was restrained by two or more people on the floor face down for more than twenty minutes. The explicit definition of what kind of restraint is being used, how it is being implemented, by whom and for how long will assist all stakeholders in exercising responsibility around restraint use.

The MA Department of Education authorizes restraint use in education programs, including public schools, charter schools, collaborative education programs, special education schools and school events and activities sponsored by such programs. The Massachusetts Department of Education currently proscribes three different types of restraint use, involving means that are physical, mechanical or chemical. A physical restraint is the use of bodily force to limit a student's freedom of movement. A less restrictive intervention is a physical escort. A physical escort is the action of touching or holding a student without the use of force for the purpose of redirecting the student. On the website provided for consumers, the MA Department of Education does not define

restraint by mechanical means (Massachusetts Department of Elementary and Secondary Education, n.d.). Containment by seclusion involves placement in a limited space or location.

The use of seclusion is prohibited in Massachusetts' public education programs. The use of chemical or mechanical restraint is prohibited unless explicitly authorized by a physician and approved in writing by the parent or guardian. The Massachusetts Department of Education states that a physical restraint that lasts more than twenty minutes is called an 'extended restraint' and acknowledges that the use of extended restraint increases the risk of injury and requires additional written documentation.

Based on the revised version from the Massachusetts Department of Education website (Massachusetts Department of Elementary and Secondary Education, n.d.), the Department provides stakeholders with information on what types of restraint schools can use. However, the Department does not fully describe how physical restraint is used in schools, and the terminology and definitions may lack important details that parents and others can benefit from learning.

TASH (2011) describes different types of restraint in more detail and explores in depth how stakeholders can better understand the use of restraint with children. In their publication, S*houldn't Schools Be Safe?* (TASH, n.d), the authors explain that parents may get reports from schools that their children were subject to "holding, restrictive procedure, restricting movement, limiting movement, pinning, cuffing, physical support, containment and/or hands-on" (p. iv), and that when these descriptions are used as synonyms of restraint, parents may not understand what is involved in the procedures. They explain that restraint generally is an aversive intervention that "involve the

deliberate infliction of physical and/or emotional pain and suffering" (TASH, n.d., p. iv) with the goal to control or to change the behavior of the child. They also explain how specific forms of restraint may have specific consequences for the welfare of the child. For example, they state that "use of restraint devices as well as blindfolds, visual screens, and white noise helmets results in sensory deprivation" (TASH, n.d., p. iv). Restraint involves the "forced restriction or immobilization of the child's body or parts of the body" (TASH, n.d., p. iv) as a consequence of a behavior presented by the child. Manual restraint involves applying various "holds" for immobilizing a child or bringing a child to the floor. Holds are prone if the restraint holds the child horizontally in a face down position, and supine if the restraint holds the child horizontally in a face up position; in both cases, the child will be "kept in the chosen restraint position by one of more staff person's arms, legs, or body weight" (TASH, n.d., p. iv). Mechanical restraint refers to the "use of straps, cuffs, mat and blanket wraps, helmets, and other devices to prevent movement and/or sense perception, often by pinning the child's limbs to a splint, wall, bed, chair, or floor" (TASH, n.d, p. iv). Thirdly, chemical restraint is "using medication to stop behavior by dulling a child's ability to move and/or think" (TASH, n.d., p. iv); excluded are prescribed medications that treat symptoms of a disability or illness.

History of Corporal Punishment in Schools

There has always been a need to manage children's behavior. From colonial times until today, corporal punishment has served this purpose. Corporal punishment in school settings exist on a continuum from time out, to spanking, to paddling, to kicking and can end in abusive and, at times, deadly aversive interventions. Physical restraint has been defined as one form of corporal punishment and serves the same purpose of managing

behavior. In the colonial period, schooling was based on face-to-face encounters in which the schoolmasters asked individuals or small group of students to recite back what they were assigned as a lesson. These masters relied on children being scared and used force in order to manage, punish and correct children. This approach involved the conscious use of force as a form of punishment for the greater good of establishing moral order in society (Butchart & McEwam, 1988).

Moral order was hierarchal: members of each stratum had power over their social inferiors and had the prerogative to use force to show their superiority. In the beginning of the 1800s, the first reform, called bureaucratic discipline, challenged this approach. Lancaster's monitorial schools demonstrated a new system, in which Lancaster "developed and deployed a form of disciplinary power that transformed relationships between teacher and student" (Butchart & McEwam, 1988, p. 23). Lancaster controlled corporal punishment, elaborated ranks and badges and put in place "a disciplinary pedagogy only for the children of the new industrial poor" (Butchart & McEwam, 1988, p. 24). This form of pedagogy provided not only basic literacy and numeracy for the children, but also what Lancaster believed to be "a proper moral training for the lower orders of urban society" (Butchart & McEwam, 1988, p. 24). The second reform, in the second quarter of the nineteenth century, was called "soft pedagogy" or "New England pedagogy" (Butchart & McEwam, 1988, p. 25). This reform still promoted an internalized authority. However, it constructed authority on "emotional ties, guilt, and an interiorized self-surveillance" called "affectionate authority" (Butchart & McEwam, 1988, p. 26). Following this reform, "bureaucratic pedagogy" emerged as a Protestant development for a brief period. Bureaucratic pedagogy celebrated capitalism,

industrialism and markets as central to the civilizing project. With this perspective, Armstrong designed specific racialized disciplines designed for the socialization of African Americans in the south after the Civil War. Armstrong proposed that Africans Americans required "individual and group internalization of the authority of a paternalistic, superior race" (Butchart & McEwam, 1988, p. 30). By the 1930s, bureaucratic pedagogy had disappeared, leaving behind its monitorial values.

In the Progressive Era of the1890s to the 1920s, very little is written about schooling despite important changes that resulted in progressive discipline and management that lasted until the 1950s. During this period, discipline was part of instruction. Misbehavior was not understood as evidence that children were sinners or unwilling; instead, it was suggested that misbehavior arose as a consequence of the demand in the classroom that children conform to an inflexible agenda. At this time, there developed a connection between the New England support of student interest and pleasure and active classrooms with a less rigid structure (Butchart & McEwam, 1998). A principle that informed this approach was that an improved environment would lead to less misbehavior. Thus, classroom management focused more on lights, ventilation, seating and other environmental issues, instead of methods for responding to rebellious behavior. The problem with child-centered progressive modalities of education was that educators assumed that self-authority could come into place with no explicit tutoring or direction. Social progressives, on the other hand, retained traditional beliefs and supported obedience to authority with a moral base.

Butchart and McEwam (1988) argue that from the 1950s until now, discussions about classroom management have been centered on practices, behaviorism and norms

guided by the dominant group. They suggest that notably missing are conversations about philosophy, relationships, connection and dignity. They account for this historical dearth of creative, in-depth discussion of education with the statement that "two centuries of employing disciplinary power of the marketplace has dramatically blunted the potential for teachers and students to reimagine educational relationships more consonant with the imperatives of democratic life and human dignity" (Butchart & McEwam, 1988, p. 41).

Throughout history, physical punishment has been a tool to educate children used by parents in the form of spanking and used in schools as corporal punishment. Corporal punishment is the "use of physical force with the intention of causing a child to experience pain, but not injury, for the purpose of correction or control of the child's behavior" (Cope, 2010, p. 167). A critical discussion that arose from the use of corporal punishment in homes and schools was the impact of corporal punishment on child development. Eron (1996) reflects on his extensive work with colleagues Huesman, Walder and Lekkowitz, on how children learn to be aggressive. One hypothesis they explored was that children who are punished by their parents for aggression will be less aggressive at school. However they found that children whose parents used severe punishment were more aggressive at school. A second hypothesis was that corporal punishment inflicted by a figure that was emotionally close to the child produced a less aggressive child. Thus, if the child had a close relationship with the father, the child would understand the corporal punishment as a mode of redirection towards a greater end. But if the child did not have close identification with the father, the child may perceive the punishment as an unjustified intrusion used by the parent to gain his own

ends. When this happened, the child learned that aggression was a way to solve problems. Thus, the child will end up modeling the punitive learned behavior (Eron, 1996). Eron concluded that the nature and closeness of relationships have to be taken into account when considering the effects of corporal punishment. Finally, Eron explores a third hypothesis, established in the sixties, that a link existed between the extent of violence that children were exposed to on television and the extent of aggressive behavior by children at school (Eron, 1996).

Hyman (1996) argues that corporal punishment had no pedagogical value. He traces the relationship between state policy on corporal punishment and reports of emotional damage of corporal punishment on children. In the United States in 1976, two states initiated a movement stopping the use of corporal punishment in their schools. The movement led to research-based advocacy and efforts that helped ban corporal punishment in 27 states (Hyman, 1996). Hyman (1996) documents that when schools inflicted corporal punishment on children, the children subsequently showed signs of physical and emotional damage. This was the case even when the practice was approved by the community. In states that banned corporal punishment, the problem of emotional damage as a consequence of corporal punishment was less prevalent (Czumbil & Hyman, 1997).

Corporal punishment became the subject of political debate. Conservatives held that corporal punishment was not a form of abuse, while liberals argued that it was (Hyman, 1996).

The argument that corporal punishment is a form of abuse is based on findings that this form of punishment has adverse effects on children's psychological health. For

example, studies show that corporal punishment is correlated in the short term with the presentation of symptoms of stress. In the long term, corporal punishment is correlated in 1-2% of cases with the development of Post-Traumatic Stress Disorder (Hyman, 1996).

In 2006, the United Nations Economic Commission for Latin America and the Caribbean (ECLAC) raised concern after discovering that legislation and policies across different nations were allowing corporal punishment of children by educators, parents and caregivers. In all the cases that were presented:

> State parties were requested to take all appropriate measures, including of a legislative nature, *to prohibit all forms of physical and mental violence* including corporal punishment within the family, schools, the juvenile justice and alternative care systems and generally within the society. (p. 6)

The United Nations Committee on the Rights of the Child suggested promoting public awareness campaigns to foster positive, nonviolent forms of discipline to ensure the preservation of children's human dignity (2006). The Committee defined corporal and physical punishment as:

> any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. Most involves hitting ("smacking", "slapping", "spanking") children, with the hand or with an implement - a whip, stick, belt, shoe, wooden spoon, etc. But it can also involve, for example, kicking, shaking or throwing children, scratching, pinching, biting, pulling hair or boxing ears, forcing children to stay in uncomfortable positions, burning, scalding or forced ingestion (for example, washing children's mouths out with soap or forcing them to swallow hot spices). In the view of the Committee, corporal punishment is invariably degrading. In addition, there are other non-physical forms of punishment that are also cruel and degrading and thus incompatible with the Convention. These include, for example, punishment which belittles, humiliates, denigrates, scapegoats, threatens, scares or ridicules the child. (p. 4)

Hyman (1996) describes the forms of injuries that result from corporal punishment in schools. These most often include red and blistering welts and hematomas on the legs and

buttocks. However, there are reports of injuries to most extremities, of internal damage and of death associated with punishment drills. Hyman observes that children with disabilities are particularly vulnerable to maltreatment at school and that a high proportion of abused children reported in the media have been in special education (Hyman, 1996).

Weiss, Dodge, Bates, and Petti (1992) observe that students with learning, attention and emotional problems that are paddled in school are often are also hit in their homes. They suggest that these children typically have learned to model the aggressive behavior of their parents; thus the implication that corporal punishment in school will *decrease* their misbehavior is unfounded.

In 1996, The American Academy of Pediatrics supported research into the effects of corporal punishment. On the basis of the findings, the American Academy of Pediatrics urged parents, educators, school administrators, school board members, legislators and others to "seek legal prohibition by all states of corporal punishment in schools and to encourage the use of alternative methods of managing student behavior" (American Academy of Pediatrics, Committee on School Health, 2000, p.1). The American Academy of Pediatrics recommended that, "Corporal punishment in schools be abolished in all states by law and that alternative forms of student behavior management be used" (American Academy of Pediatrics, Committee on School Health, 2000, p.1). They stated that the student's concept of the self may be adversely affected by corporal punishment and that, as a consequence, the student may become violent and present disruptive behavior.

Czumbil and Hyman (1997), reviewed abuses of legalized corporal punishment in schools by researching newspapers articles from 1975 through 1992. They found that males were far more likely than females to receive corporal punishment. Also, the majority of reports came from the South Atlantic region of the United States (MD, WV, DC, DE, VA, NC, SC, GA and FL). As there is no federal legislation against corporal punishment in schools, and some states still use corporal punishment as a tool to educate children in schools, the analysis of the abuses is in those settings that corporal punishment is legal. The case studies from these events are the ones that have been analyzed (Czumbil & Hyman, 1997).

An identified problem is the lack of accurate data on the severity of school paddlings. The Office of Civil Rights conducted surveys of corporal punishment; however, Russell (as cited in Czumbil & Hyman, 1997) found that some schools did not answer the surveys. Hyman (1990) reported that the national range of the incidence of corporal punishment between 1975 and 1992 was estimated to be around 1,332,317 to 1,521,896.

Czumbil and Hyman (1997) come to a number of conclusions regarding the practice of corporal punishment in schools. One conclusion is that if authorities have the power to inflict power, it will sometimes be the case that this power will be abused. It is also suggested that if parents were the offenders, they would have been prosecuted. They also make the case that it is highly likely the number of abuses at schools is underrepresented. Finally corporal punishment in schools is inherently ineffective (Czumbil and Hyman 1997).

Despite the findings of the above research that corporal punishment is an ineffective and harmful means of discipline, the practice of corporal punishment continues to be used frequently across the United States (Eron, 1996). Fifteen years later, the ACLU/HRW still has concerns regarding the detrimental consequences of these practices in schools (2010). As stated above, the practice is most frequently found in schools located in the South and Southwest. Florida, Texas, Arkansas and Alabama use the most corporal punishment and are recognized as leaders "in the hit parade" (Hyman, 1996, p. 820). Hyman makes reference to one study which suggests, "teachers who frequently paddle tend to be authoritarian, dogmatic, relatively inexperienced, impulsive and neurotic compared with their peers" (Hyman, 1996, p. 820).

Hyman (1990) and Farley (1983) argue that a better way for communities, schools and families to succeed is to replace corporal punishment with prevention, moral persuasion and alternative punishments (Hyman, 1990; Farley, 1983). Hyman, in collaboration with other researchers, reviewed the most widely used discipline training programs for teachers. The authors found that none of these training programs recommended corporal punishment as necessary or effective. The authors state that aggression and child abuse will dramatically diminish if corporal punishment is replaced by positive motivational techniques, incentives to good behavior and nonphysical punishments (Hyman et al., 1996). The irony of the use of corporal punishment in schools to force better behavior is captured in the quote below:

> Corporal punishment is often used when a child has behaved aggressively. The irony is that the behavior is stopped by the teacher, in turn, being aggressive towards the student. A special education teacher made this observation "I see these autistic children who get in fights and then get paddled. So you're supposed to teach them not to hit by hitting them. (ACLU/HRW, 2009, p. 34)

Literature in Support of Corporal Punishment in Schools

Little research is available that supports corporal punishment in schools. Hyman (1996) writes that there are no such studies. However, he argues that some researchers support moderate parental spanking. He also writes that some defenders of corporal punishment in school settings state that it works and that localities should make the decision about its use as a measure of control to maintain discipline. These defenders argue that only *abuse* of corporal punishment is highlighted in the media and that these extreme cases should not be the basis for delineating policy. However, he makes the point that the majority of abuses that he and his group investigated were legally sanctioned and that local teachers, unions, administrators and school boards had defended the teachers' actions. He writes that there was no accountability for the fact that the children who had been the recipients of these abuses of corporal punishment had observable physical injuries that would have been reportable by the school had they had been inflicted by a parent or any other adult (Hyman 1996).

Butchart and McEwan (1998) state that a better understanding of the history of classroom discipline will lead to better awareness of how teachers and schools select practices, what professional habits they foster and what cultural blinders are in place. They argue that perhaps corporal punishment is an organizing principle that supports the history of classroom discipline, and perhaps it is declining in an era when other organizing principles are taking precedence, and perhaps testing and following standardized curricula take over as disciplining practices (Butchart & McEwam, 1988). However, they said that some will disagree and will miss the power of favoring corporal punishment because "in the popular imagination, and in the minds of some politicians,

the disappearance of the rod is lamentable. Schools were safer, more orderly places with more learning going on when teachers ruled with the ferule or the paddle" (Butchart and McEwan, 1998, p. 21).

In addition to paddling, other forms of violent discipline are often used against students with disabilities. Corporal punishment is defined by the United Nations Committee on the Rights of the Child as "any punishment in which physical force is used and intended to cause some degree of pain or discomfort" (as cited in ACLU/HRW, 2009, p. 3), though there is no comprehensive definition of corporal punishment under US state or federal law. The ACLU/HRW documented cases of corporal punishment, including hitting children with a belt, a ruler, a set of rulers taped together, or a toy hammer; pinching, slapping, or striking very young children in particular; grabbing children around the arm, the neck, or elsewhere with enough force to bruise; throwing children to the floor; slamming a child into a wall; dragging children across floors; and bruising or otherwise injuring children in the course of restraint. Corporal punishment is prohibited under international law and in many US settings, including most juvenile correction facilities, yet it continues in public schools (ACLU/HRW, 2009).

Change can be difficult for systems that are rigidly established or settled, it may feel like a loss, it may be a sentiment of nostalgia for the days that are gone where things and order seemed to be in place. Because this doctoral project does not address parents' methods of discipline, it is suggested that the reader consult Cope (2010) for a guidelines on reasonableness standards in the context of corporal punishment by parents. For a discussion of parental discipline of young children, see Socolar, Savage, and Evans (2007).

The Use of Restraint in Public Schools

The Council for Children with Behavioral Disorders (CCBD), a Division of the Council for Exceptional Children, states that very little research has been conducted on the prevalence, appropriate applications or efficacy of physical restraint (2009). Additionally, there has been a lack of research on the use of restraint in school settings. Consequently, there is both a lack of data on what types of restraint schools are using and inadequate reporting of injuries due to restraint. What is documented, however, is that the use of prone restraint is an unsafe and dangerous form of managing children (NDRN, 2009). Also unknown is the extent or nature of teacher or staff injuries resulting from the implementation of a restraint. Limited data impedes learning of what types of physical restraint are most commonly employed as well as the nature and extent of training received by educators who apply physical restraint. It is safe to assume that most professionals working with children in school settings view restraint as an emergency procedure. However, little is known about its intended purpose or outcomes when it is employed, let alone whether it is effective in achieving the desired outcomes (NDRN, 2009).

Mandates of No Child Left Behind and Individuals with Disabilities Education Act (IDEA) promote reliance on evidence-based practices, with decision-making based on research and therapeutic and safe approaches. However, one important problem is that such evidence-based data are not available at this time because of ignorance or lack of knowledge on the use of restraint. Policies and laws on restraint prevention and reduction are the result of efforts by concerned groups in some states. However, lack of local, state

and federal regulations and laws render it difficult for all educators to rely on evidence-based practices.

The latest research indicates that there are serious risks and dangers connected with this procedure, and the practice is made more ambiguous by the underlying myths and assumptions held by members of the public (Centers for Medicare and Medicaid Services [CMS], 2006). Additionally, Mohr et al. (2010) found that even though the federal government and professionals were paying more attention to restraint use, the field of mental health was still uninformed of the risks connected with physical restraint. They also found that the field lacked serious research-based information conducive to solid understanding. Some available mental health resources still use the euphemism "therapeutic hold" for the use of restraint in spite of regulated definitions that acknowledge that restraint is not therapeutic (Mohr et al., 2010).

At this time, there is no federal R/S statute. Until now, all that exist are analyses of states' R/S laws and policies. Furthermore, state laws are not uniform; they "vary widely—a patchwork of laws, regulations, voluntary guidance, and complete silence covering the nation. Parents and the public are often ignorant of what the state laws are" (Butler, 2012, p. I-2). Currently, twenty-nine states provide meaningful legal protection against R/S. New Hampshire protects all students from restraint and specifies protection for students with disability from seclusion:

> Ideally, all children should be protected from restraint/ seclusion. Nonetheless, because these techniques have been used frequently upon children with disabilities, as they have disproportionately suffered death, injury, and trauma, special care is often taken to protect their rights and safety. (Butler, 2012, p. I-3)

Concerning the use of restraint in schools, Ferleger (2008) argues that despite the fact that students have sustained injuries and have sometimes even died while being restrained, courts have not condemned the responsible parties in public schools. It is explicitly stated in *The Use of Seclusion and Restraint in Public Schools: Legal Issues* (Jones & Feder, 2009) that, "Federal law does not contain general provisions relating to the use of seclusion and restraint" (p. 1). The report describes the recent activities by Congress and the General Accounting Office to document hundreds of cases of alleged abuse and death due to the use of restraint and to report on relevant state laws. The report gives definitions of R/S, including mechanical restraint as used by the Education Department. The report then reviews the relevant case law, noting the relevance of due process claims under the Fourteenth Amendment and unreasonable searches and seizures under the Fourth Amendment. Generally those claims are only successful when the use of R/S "shocks the conscience." It also describes a reasonableness standard, noting that the court must defer to qualified professionals to determine reasonableness. It also notes that some courts have determined that due process claims are best brought under state tort law.

The Council of Parents, Attorneys and Advocates (COPAA) published a document entitled *The Right to be Safe in School* (Sullivan, 2011), in which it is argued that schools must be safe places. The authors assert that R/S is an aversive technique that harms children with disabilities, and they consider those interventions an abuse that should not have a place at school. COPAA developed a manual to guide attorneys and advocates that represent children with disabilities who were injured or damaged at school

by those unsound and harmful techniques and states that there are state and federal complaints to challenge the use of R/S.

The state complaint procedure, based on the Individuals with Disabilities Education Act (IDEA), requires that each State Education Agency (SEA) adopt a process that allows an individual and/or an organization to complain about a local education agency (LEA). The basis for the complaint may be "any matter relating to the identification, evaluation, or educational placement of the child, or the provision of a free appropriate public education to such child" (Sullivan, 2011, p. 21). However, IDEA does not prohibit the use of restraint. Thus, the fact that a restraint occurs is not a basis to file a complaint. Furthermore, states at this time do not have uniform policies. Finally, the complaint has limitations. For example, one aggravating circumstance is the existence of a two-year statute of limitations and the fact that monetary damages are neither available under IDEA nor enforceable by the SEA (Jones & Feder, 2009).

There are records of cases in which the use of R/S has been described as a disability-based discrimination; this has happened when the use of restraint was excessive or punitive or because the behavior of the students was a manifestation of his or her disability. A comparison can be made with the case of the School Resource Officer (SRO) who expected a fidgety child to stay still when such behavior was not an option for the child due to the child's inability to control the fidgeting. The Office for Civil Rights (OCR), overseen by the United States Department of Education, enforces federal laws against discrimination and includes prohibition of disability-based discrimination. Affected people can file a complaint with the OCR. However, the OCR cannot order a

court to enforce a solution. Also, any complaint must be filed within 180 calendar days from the date in which the discrimination took place.

The Council of Parent Attorneys and Advocates (COPAA) explored the risks associated with using school security or police officers to employ R/S techniques (Sullivan, 2011). In most school districts, a school resource officer (SRO) is a law enforcement officer, employed by the local or county law enforcement agency and assigned to the school district through a cooperative arrangement between those two entities. In other districts, an SRO is a school district employee with full police powers. In still other school districts, each school may employ a civilian to serve as the school security officer. This person does not have full police powers and is not trained as a law enforcement officer. Additionally, training is not homogeneous for SROs across states, and some do not include information on how to work with students with disabilities. COPAA cited an example in which an SRO handcuffed a student because he could not stop fidgeting. In addition, COPAA found that students can be tasered and, at times, school personnel rely on the SRO to perform restraint instead of using proper de-escalation strategies. COPAA suggested having the SRO participate in the Individualized Educations Plan (IEP), educating SROs on behavioral intervention plans and supporting the training of SROs so that teachers and administrators were more aware of disabilities and the use of de-escalations strategies instead of assuming that the use of physical force was the best procedure.

Plaintiffs have brought claims against state actors for the use of R/S on students under a number of federal and state laws (Sullivan, 2011). Section 1983 is a vehicle to

remedy violations; however, section 1983 must be used in conjunction with another federal law, as it alone does not create any substantive rights.

The report by COPAA (Sullivan, 2011) outlines a legal strategy under federal law to reduce the use of restraint by citing Title 42 U.S.C. § 1983: US Code - Section 1983: Civil Action for Deprivation of Rights. That statute allows a student to bring a constitutional or federal claim against a school official for the use of R/S. Claims made under IDEA, Section 504 and ADA can be brought directly under those statutes. A Section 1983 lawsuit is used to assert a student's right to be free from unreasonable seizure (restraint) under the Fourth Amendment to the US Constitution or to be free from bodily restraint under the Fourteenth Amendment. There are a number of legal defenses school employees and school systems can take to assert immunity and defend against claims under Section 1983. The questions of immunity and applicability of Section 1983 must be resolved before the student is required to prove the underlying elements of the claim. Section 1983 is a challenging legal approach but it affords another avenue for redress outside IDEA and special needs legislation.

In his report, Sullivan presented seven cases in which young students died as result of restraint in schools, residential and psychiatric settings between 2002 and 2007, and this is not an exhaustive list. He also presented six cases of youth with disabilities, including a second grader who suffered from repeated restraint by being wrapped in a sheet with tape to secure it, having water thrown at his face, having bruising on his arms due to having been forcibly held behind his back and being isolated and restrained without his parent's consent.

While there are as yet no laws against restraint, Senator Harkin (D-IA) has responded to concerns by introducing the Keeping All Students Safe Act (S. 2020, 2012). This act serves to limit the types of restraint allowable in schools and to provide guidelines designed to minimize damage to children from the use of restraint. The act would (1) prohibit the use of mechanical restraint, chemical restraint, or physical restraint that restrict breathing; (2) prevent the inclusion of R/S in a student's IEP; (3) prohibit physical restraint except in emergency situations; and (4) require debriefing sessions with parents and staff (The Capitol Insider, 2012, January 17).

Schools across the US use restraint, and the ACLU/HRW report receiving allegations of abuse of restraint from all states (2009). In particular, numerous cases have been documented of bruises and serious injuries resulting from restraint. Several families reported that prone restraint was used on their children. Prone restraint is a form of restraint "in which a child is pinned face-down to the floor, often with his hands pulled behind his back. Prone restraint is 'one of the most lethal school practices': sudden fatal cardiac arrhythmia or respiratory arrest can occur through prone restraint" (ACLU/HRW, 2009, p. 23). The NDRN (2009) documented three cases in which students died after a prone restraint. Even when not lethal, prone restraint can have serious effects on a person. Cases of lacerations, bruises, deprivation of oxygen to the brain and blunt trauma to the head have been documented as a result of prone restraint. The seriousness of the possible effects of prone restraint use has led the ACLU/HRW to state that, "Face-down restraint is extremely dangerous and never appropriate. It does not meet international standards requiring the minimum use of force for the shortest period of time, and it should be absolutely prohibited in schools" (2009, p. 24).

Other kinds of restraint use include "holds" or vertical restraint. Parents have reported that their children were bruised or severely injured by this type of restraint. A teacher said to a mother that:

> A new technique was used on her (daughter) to place her in a hold that would intentionally cause discomfort in order to deter future misbehavior. The use of force with the intent to cause discomfort amounts to corporal punishment, not permissible restraint. (ACLU/HRW, 2009, p. 25)

The ACLU/HRW stated that they received multiple reports where students were punished because of, or as a consequence of, their disability (2009, p. 25). Parents said that school personnel refused to take their children's disabilities as a factor when they selected the way to administer discipline. Parents also said that, as a consequence of behavior related to their disability, their children were being beaten even though the behavior was inseparable from their disability and completely out of the child's control. One case included was a mother whose child suffered both Tourette Syndrome and Autism conditions. She reported:

> One of his tics was balling up his fists… that was seen as aggression and he would get in trouble with it…. He would try to explain that it was a tic, and he couldn't control it, but they see that as him escalating it. So now they have him in restraints and then they're giving him sedatives and calling for me to come pick him up. They had a closet and he would go in there and that's where he was hit. (ACLU/HRW, 2009, p. 35)

Children with autism are punished for the behaviors they present that are part of their disability, such as spinning, difficulty transitioning, difficulties socializing with other children, being "theme obsessed," acting in repetitive ways and rocking (ACLU/HRW, 2009). Educators, who face the difficult task of maintaining order in the classroom, may resort to corporal punishment because it is quick to administer or because the school lacks resources and training for alternative methods of discipline. One teacher

pointed out that corporal punishment could be considered 'cost-effective': "It's free, basically. You don't have to be organized. All you need is a paddle" (ACLU/HRW, 2009, p. 39). Logistical or financial obstacles may prevent teachers from using other methods of discipline. One 18-year-old student who was critical of the use of corporal punishment in his rural school district stated, "We couldn't have after school detention. There was no busing. Kids who got detention would have to find another way home" (ACLU/HRW, 2009, p. 39). Yet despite the "convenience" of corporal punishment, teachers we interviewed noted that it was ineffective. As a middle school teacher stated, "The immediate impact is to get that student to stop that behavior, but there is no guarantee that it [won't] continue" (ACLU/HRW, 2009, p. 39). "Educators may use corporal punishment against students with disabilities in part because they have little to no understanding of the consequences of those disabilities" (ACLU/HRW, 2009, p. 39). What educators may be missing is that the disability may be the lead source to non-normative behaviors in the classroom.

Impact of R/S

So far, the literature reviewed has demonstrated that, as a form of corporal punishment, restraint use has negative consequences. It has been established that restraint use is harmful. Children are physically injured and in some cases die. Restraint use also causes traumatic and psychological damage, in some cases Post-Traumatic Stress Disorder (Hyman, 1996). A finding from data reviewed by the ACLU/HRW (2009) suggests that students with disabilities seem to be disproportionally represented in the population of students who receive restraint, and there has been shown to be a link between having a disability and being punished in school.

However the impact of corporal punishment and restraint goes beyond those damaging issues:

> Corporal punishment teaches students that violence is acceptable: it can make students aggressive, angry, and more likely to lash out in school. Students can become less engaged in school, less motivated to succeed, and may become more likely to drop out. Students with disabilities, who are already marginalized in academic settings, may find that corporal punishment establishes additional barriers to inclusive education. (ACLU/HRW, 2009 p. 41)

The ACLU/HRW report that the effects of these techniques go beyond the school years, as students become angry, depressed, suicidal and disenchanted with learning and academics. They also report that the physical injuries sustained from being restrained sometimes aggravate the student's medical condition and delay developmental milestones. Because autism affects communication and social skills, children in the spectrum are especially traumatized by corporal punishment and restraint. And behavioral consequences of being restrained can be regression, self-injury, fear of school and increased aggressive behavior (ACLU/HRW, 2009).

The ACLU/HRW also states that restraint use has consequences for the wellbeing of the student's family. Families report lacking information in the first place. Parents in such a situation may not be aware of what is happening at school and may therefore not be in a strong position to protect their children. Because most families do not know the school system, their rights or the rights of their children, they may become isolated, concerned and frustrated. They sometimes must use financial resources to pay for attorneys and advocates that can support their case. The family may need to withdraw the child from school to protect his or her safety, and this will have implications for the child's access to educational services. The parent may lose their job, and the school may

charge the child (family) with truant behavior. One parent remarked, “Retaliation is horrible in this county [in Georgia]. If I kept [my son] out, they’d write me up for truancy” (ACLU/HRW, 2009, p. 51).

Parents may feel guilty because they have not been able to protect their child from harm. However, some parents have fought back, got organized, joined support groups and conducted legal research. As one parent remarked, “If parents knew that schools do this, the kids wouldn’t be hurt. You try to tell them, you all have rights. That’s why we started this support system. That’s when [the abuse against my son] stopped” (ACLU/HRW, 2009, p. 52).

Disabilities Rights California (DRC) is an organization that is committed to educating the public to improve the safety of people with disabilities. To ensure that the public is well informed of the dangers and hazards of prone restraint, DRC has the goal of persuading professionals in the health care arena to eliminate this practice and to support a paradigm shift from viewing prone restraint as a treatment intervention to identifying it as a therapeutic failure. To stress the point about the particular danger of prone restraint, “Prone restraint is the extended restraint (either physical or mechanical) of an individual. This may include holding an individual past the time of immediate struggle. It also includes restraint to a bed using restraint devices, such as leather cuffs” (Morrison et al., 2002, p. 7). In this report the authors presented seven cases of harm resulting from use of a prone restraint. In six cases, the students died, and in one case, the student incurred an injury that led to a severe disability. The age range was from 16 to 47 years. The 16 year-old-girl was a student at an on-site school program for children with disabilities.

> There are realistic risks of injury to both the restrained individual and employees during floor-assisted prone restraint. The greatest risk of injury seems to be during the period the restrained individual is being assisted to the floor from a standing position. The restrained individual often suffers bumps, scrapes, small bruises, and small cuts from impact with the floor. Employees suffer similar injuries…. The restraint team should avoid any position that puts pressure across the attacker's torso, long bones, joints, spinal cord. Care should also be taken to avoid contact with sexual areas. (Smith, as cited by Morrison et al. 2002, p. 24)

Morrison et al. (2002) also present alternatives to restraint and useful lessons learned from experiences in the state of Pennsylvania. Their findings will be explored later in the alternatives to restraint section.

In the Child Welfare League of America's September/October 2003 *Children's Voice* issue, Scott Kirkwood wrote an article "More Harm than Good" and reported on several experts from different regions of the United States that agreed with the fact that restraint has negative effects. One professional writes:

> Children who are victims or witnesses to abuse experience significant changes in the way they regulate their emotions over time, creating all kinds of problems as they get older, and yet as these children escape violent, abusive surroundings, they are all too often subject to violence in a venue designed to protect them. (Huckshorn, as cited by Kirkwood, 2003, More Harm than Good section, para. 4)

The following quote challenges the notion that restraints are therapeutic:

> I think we've confused what's therapeutic in terms of intervention. There was a tacit belief that containing children, setting harsh limits, and imposing a physical restraint or seclusion was somehow therapeutic. How we got the idea that meeting a child's history with violence was somehow going to be palliative and restorative, we don't know. (LeBel, as cited by Kirkwood, 2003, More Harm than Good section, para. 5)

When one considers traumatized youth, it is key to recognize that past trauma influences how youth respond to present circumstances. When personnel are not sensitive to this fact, it is possible that they may generate triggers that lead to explosive behavior when

they exacerbate anxiety-levels in youth and then use force in their efforts to control the explosive behavior that results: “In reviewing restraint episodes involving children, we noticed a pattern, when kids were in trouble and in distress, the staff would set limits, and the kids would then become more agitated--a recipe for restraint” (Stromberg, as cited by Kirkwood, 2003, More Harm than Good section, para. 6).

Another explanation for the escalating behavior from a child that leads to increased restraint use is the phenomenon of counteraggression. If a child perceives behavior from an adult as an attack, the child may respond by being aggressive back, as the quote below elucidates:

> Research that looks at why restraint increases [stress] points to the phenomenon of counteraggression. When you feel like you're being attacked, there may be an [instinctive] reaction, and a staff member [may be contributing to that situation]. Counteraggression prevents people from being able to let those verbal assaults or other things go. Everyone [is vulnerable to counteraggression], whether they admit it or not, but the extent to which it happens decreases with experience and training. (Jones, as cited by Kirkwood, 2003, More Harm than Good section, para. 7)

Essential Youth Voices

Youth voices are, for the most part, invisible in the literature reviewed. However, *Children’s Voice* presented the voices of youth from a forum in Westborough, Massachusetts in an article entitled “Reducing Restraint and Seclusion” (Caldwell & LeBel, 2010). The children were recipients of services by child welfare, mental health services and juvenile systems services. It is not possible to honor the voices of the children that are no longer living. However lessons can be learned from the ones that had the opportunity to try to educate adults towards a non-violent path.

The words of children in their own voices may help adults to identify fear, lack of control and disempowerment. Solomon, 16 years old, said, “I figured it out: When you

see staff running at you, just lay down on the floor and then you just ask God to not make it hurt and wait for it to be over. It's shorter that way--and you don't get hurt as much." Some people use their own pain as a tool to make changes that can benefit society. For example, Brenda, 17 years old: "The first time I got restrained was when I was six, in a hospital," she said. "I want to go to law school and become a lawyer so I can help other kids one day, so this doesn't happen to them. Restraints only set kids back and make them distrust staff and adults."

The literature raises awareness that teachers and staff who cause harm to a child when using a restraint are protected by educational and mental health systems, whereas parents, legal guardians and foster parents would be prosecuted for the same actions.

A powerful statement from a young woman illustrates the devastating and long term consequences of restraint use on how children "learn" to make sense of and respond to the world. Alisha, 18 years old, stated, "Restraining and secluding someone isn't just tying them down or locking them up--it affects everyone. But it's harder for kids because we don't have the power. It teaches [us to] resolve our problems with violence. I think what's important is that we respect each other, listen, and not touch anyone without their permission."

APRAIS (2005) presented seven cases in which four children got hurt and three died while being ostensibly "treated" for their challenging behaviors. The ages ranged from three to 14 and most of them were affected by autism and cognitive disabilities APRAIS reported that children with disabilities are affected on a daily basis by harmful practices as a way of managing their behaviors.

Lai and Wong (2008) presented the perspectives of 25 families of children who have been restrained. Although the results are limited and cannot be generalized, they are significant for what they reveal about most families' lack of knowledge about restraint use and how this may affect the welfare of their child. The researchers found that most of the families did not know that alternatives to physical restraint were available, they did not have an opinion on its use and they thought that physical restraint was useful. The researchers recommended that schools inform and educate such families and involve them in the decision making process in any situation where physical restraint is being used.

Legal and Ethical Issues

Corporal punishment is an approved and legal tool to discipline children in 23 states, and abuses of the use of corporal punishment are overrepresented in the states where corporal punishment is approved and under-represented in other states. Research has provided documentation that corporal punishment inflicts physical and psychological damage on children. We also learned that restraint is described as a form of corporal punishment. Pertinent literature informs us that R/S are legal tools used in public school settings to control and manage children's behavior, and R/S causes physical and psychological damage in children. Before discussing actual situations of restraint use and abuse in schools, it is relevant to outline what the legal framework is for the use of restraint in America and how it developed.

Ferleger (2008) argues that there is a right from the Constitution to be free from bodily restraint. This was the standard that the Supreme Court announced in *Youngberg v. Romeo* (1982). Additionally, a standard of care identified by the Center for Medicare

and Medicaid Services (CMS) establishes that patients have the right to be free from R/S in any form (2008). However, Ferleger argues that in general, courts have not established barriers against the use of restraint. He also said that the courts have ignored the research findings on the risks created by the use of restraint in their written opinions. On the contrary, courts have historically supported the use of these techniques.

Ferleger states that the courts have not been providing a full account of the history and nature of restraint, the dearth of evidence of efficacy, the high risk or the weight of professional opinion. He argues that the courts will soon have to recognize the fragility of the prior decisions upholding restraint and become much more skeptical about claims that restraint is therapeutic. His hope is that, as this happens, courts will reject the argument by schools or facilities that restraint is efficacious as a treatment or educational technique (Ferleger, 2008).

However, advocates have pushed for changes in the use of restraint to protect vulnerable people in healthcare institutions. In particular, incremental legislative changes have taken place as a result of concern to improve quality of care for the elderly. Geriatric literature has provided important debates on the issue of restraint use. Evans and Strumpf (1990) argued that myths about the efficacy of restraint were powerful determinants related to the practice of using restraint in caring for the elderly. The authors presented cogent arguments that served to debunk those myths. Their work was directly responsible for reforms that limit and regulate the use of restraint that occurred within the nursing home industry during the 1990s (Mohr & Anderson, 2001).

As has already been discussed, a 1998 report from journalists in Connecticut (Weiss, Altimari, Blint, & Megan, 1998) reported of 142 deaths in the preceding decade

as a consequence of physical restraint across the United States. Twenty six percent of those deaths were children, and additional statistical estimates suggested un-accounted estimate of 50 to 150 deaths (Mohr & Anderson, 2001). After the 1998 report, the National Alliance for the Mentally Ill (NAMI) created a coalition of advocacy groups to conduct their own research into this issue. A year later, following requests by Senators Dodd and Lieberman, the United States Government Accounting Office (GAO) conducted their own investigation. Their research confirmed the legitimacy of the media's accounts of the misuse of restraint (Mohr & Anderson, 2001).

Once NAMI's report, "Cries of Anguish" was released, the United States Congress commissioned hearings in 1999 to create laws to monitor the use of R/S in psychiatric facilities. In the same year, the United States Health Care Financing Administration created guidelines for restraint use in psychiatric settings, and adherence was necessary in order to be able to participate in federally reimbursed programs:

> There are numerous ethical and legal issues that have also come to be considered in the use of restraints. Our first responsibility as mental health professionals is to "do no harm," which is relevant in the use of physical restraint when not necessary, the misuse of physical restraint, and also in doing nothing when there is imminent risk of danger. (Thomann, 2009, p. 42)

Challenging the Use of Restraint in Public Schools

The use of R/S in public schools in the United States is a practice based on faulty assumptions; R/S are regarded by schools and the public generally as a safe and even sometimes therapeutic method of learning. Research has shown that restraint acts more like a punishment and causes the same kinds of suffering that has been linked with punishment. This section will review the writings of researchers Mohr and Anderson (2001), who summarize the literature on the topic with the aim of challenging the notion

of restraint. Additional takes on this matter by researchers LeBel and Butler and organizations such as the ACLU/HRW and the NDRN will be discussed. These researchers illustrate how restraint is, in fact, used in many schools across the United States along with paddling and other forms of violence as a form of corporal punishment.

Mohr and Anderson (2001) systematically challenge the assumptions that provide the rationale for the use of restraint. The first assumption is that, "There is an adequate body of empirical evidence supporting the use of restraint and seclusion" (p. 141). Mohr and Anderson argue that it is consensus, not research, which drives the use of R/S. By contrast, they argue, the available literature provides evidence of the adverse nature of restraint use.

The second assumption is that, "Unit staff members know how to recognize potentially violent situations" (p. 141). Available literature suggests that some staff is quite skilled; however, in his 2001 study on nursing, Morrison raised concern about how to evaluate nursing care. In his study of two groups of psychiatric and non-psychiatric nurses' perceptions of a measure for harmful behavior (as cited in Mohr & Anderson, 2001, p. 144), he found substantial disagreement regarding the seriousness of the items within and between the two groups. Holzworth and Wills' study in nursing judgment (as cited in Mohr & Anderson, 2001, p. 145), based on the collection of strategic recommendations for 80 patients, showed that only a third of the nurses agreed on the use of R/S, while multiple and divergent recommendations were provided for what should be done. This study demonstrates the lack of overall consistency in perceptions of how to evaluate and respond to specific cases in nursing.

The third assumption examined by Mohr and Anderson is that, "Staff members know how to de-escalate potentially violent situations and employ least restrictive measures prior to resorting to restraints" (2001, p. 145). They argue that in order to de-escalate a situation in a school setting, it is necessary to recognize the possibility of violence, to accurately assess the situation and to be empathic with children. It also requires the capacity to communicate with young children in a way that could not be perceived as threatening. In order to de-escalate, it is necessary to know how to use a different alternative to R/S. Supporting this argument is research in psychiatry that suggests that initial signs of upcoming violence are not registered due to insufficient contact between staff and patients or inadequate assessments (Aragon & Holmes; Rosenhan, as cited in Mohr & Anderson, 2001, p. 145). The authors also cite research suggesting that use of restraint increases when desirable behavior in adult patients was not adequately reinforced (Niemeier; Burdett & Milne, as cited in Mohr & Anderson, 2001, p. 145). Mohr and Anderson cite literature by Morrison (p. 145) that links the use of restraint with pervasive toughness and aggression on the part of staff towards patients rather than therapeutic positive interventions. They also describe that a variable that happened frequently before the use of restraint was a staff-initiated encounter with children and adolescents in inpatient settings and unresponsiveness on the part of the patient or multiple exchanges ending up in the staff member's use of restraint as a coercive measure.

The fourth assumption discussed by Mohr and Anderson is that, "Staff members are adequately trained in the use of restraints" (2001, p. 146). Mohr and Anderson cite research by Stillwell (p. 146) designed to provide information on the number of hours of

instruction that nurses received on the use of restraint on children in their preparation programs. According to this study, 51.8% of 168 nurses reported none, 26.2% reported less than an hour, and less than 8% were aware of death as a potential risk from a restraint. Stillwell suggests that in contrast with the wide assumption that nurses were best educated to manage this event, they in fact frequently did not know how to proceed safely and often were not aware of the consequences of restraint.

The fifth assumption raised by Mohr and Anderson is that, "Restraints do not constitute punishment" (2001, p. 146). In the majority of cases, programs that work with children and adolescents use behavior modification principles. Thus, if the behavior is positive, reinforcement is given to encourage that behavior; on the contrary, if the behavior is negative, a punishment is given as a way to control the behavior and to teach the child to do something different. Bandura, Hall et al., and Strauss define punishment as the infliction of pain, an aversive stimulus or consequence or the painful confinement of a person as a penalty for an offense (as cited by Mohr & Anderson, 2001, p. 146). According to this assumption, the use of restraint is one form of punishment used to manage and control behavior in schools.

The sixth assumption is that, "Restraint is an effective intervention as part of a unit management" (Mohr and Anderson, 2001, p. 146). This quote refers to the finding that restraint has proved to be an effective way of protecting the person in trouble as well as other people in the area. However, while it may stop the undesired action at the moment, research concludes that when children lack the capacity to understand contingency-based interventions, they may actually be counter-productive (Greene; Papolos & Papolos, as cited in Mohr and Anderson, 2001, p. 146).

The American Academy of Child and Adolescent Psychiatry and American Psychiatric Nurses Association, along with child welfare advocates (e.g., Greene, Ablon, & Martin, 2006; LeBel et al., 2004), began challenging the use of restraint by developing creative alternatives to their use (Mohr, LeBel, O'Halloran, & Preustch, 2010). Mohr, Petti, and Mohr (2003) found that mental health personnel have a set of measures used to keep patients under control. One such technique to control patient behavior is the use of restraint. They argue that the use of restraint is unsafe for people based on their finding that children are at a particularly high risk of danger as a result of the use of restraint. In their own medical terminology, they described that:

> The most common cause of death from restraint is asphyxia due to impaired respiratory functioning. However, other causes may include aspiration, blunt trauma to the chest (commotion cordis), malignant cathecholamine-induced cardiac dysrrythmias, thromboemboilis, and overwhelming metabolic acidosis from intense struggle. (p. 95)

The collaborative approach of parents, mental health clinicians, advocates and additional parties, supported by the NDRN, eventually led Congress to request a GAO report on the issue. The latest pending legislation (HR 4247 and S. 2860), and support by the White House, promote conversations and attention to groups that foster wellbeing for children with disabilities as well as interested parties for change. At the same time, several state coalitions and task forces were formed to promote change of restraint use. Although change on the state level has been slow, there have been positive results in the few states that have enacted and/or strengthened laws. Furthermore, there is now a minimum federal requirement to foster protection for school children from abusive forms of R/S across the nation (NDRN, 2009).

The ACLU/HRW documented cases of bruises and serious injuries sustained by school children with disabilities following being put in restraints or holds. Educators may use force under limited circumstances to ensure a safe environment for their students. Under international law:

> In 'exceptional circumstances ... dangerous behavior [may] justif[y] the use of reasonable restraint,' but that force must be the minimum amount necessary for the shortest period of time, and must never be used to punish. Educators must be trained to respond to dangerous behavior, 'both to minimize the necessity to use restraint and to ensure that any methods used are safe and proportionate to the situation and do not involve the deliberate infliction of pain.' (ACLU/HRW, 2009, p. 23)

A recent publication, *How Safe Is The Schoolhouse?* (Butler, 2012), provides multiple citations that confirm devastating events of death, injuries and trauma on hundreds of school children. Butler's citations come from the national governmental and non-governmental organizations and advocacy groups such as GAO, NDRN, COPAA, TASH and the Council for Exceptional Children's CCBD. For more than 20 years, evidence has been collected that confirms a great amount of physical and psychological damage because of R/S. According to the NDRN, abusive interventions are used on children in 2/3 of states and COPAA reported 185 cases that follow the pattern of aversive techniques used on young children (as cited in Butler, 2012, p. I-1). In addition, the Council for Exceptional Children's CCBD provides evidence of an ample variety of injuries and deaths that follow the pervasive use of R/S techniques in educational and other settings (as cited in Butler, 2012, p. I-1).

The statistics show how many students were hit, but they do not show how many times a single student experienced corporal punishment. There is also evidence that some school districts do not report all incidents and, in some states, there is no protocol that

mandates such information should be provided. There were many incidents of corporal punishment outside of paddling that were not reported. It was also found that some schools in states without legal corporal punishment,

> [m]ay nonetheless use violent techniques against students with disabilities; such instances are not reported to OCR. For instance, in the course of restraint in states throughout the US, students are subjected to violent discipline that can amount to corporal punishment. Furthermore, there is no federal reporting requirement for the use of restraint, and only two states (California and Connecticut) require annual reporting on the use of restraints. (ACLU/HRW, 2009, pp. 30-31)

It was found that parents of children with disabilities are usually unable to get information about restraint from school even though their children continue to be subjected to ongoing physical force while at school. The report suggests that if parents cannot collect this information, systematic reporting of restraint use is not possible. It was found that parents repeatedly reported that they did not know what kind of force was used against their children. The parents also suggested that school administrators did not want the parents to have access to this information. In a 2009 study on restraint and other abusive practices by the Council of Parent Attorneys and Advocates (as cited in ACLU/HRW, 2009, p. 31), 71% of the parents did not consent to the use of such practices on their children; however, the incidents took place. Another issue is that students with disabilities may have less ability to communicate verbally and, for this reason, they may be unable to let their parents know what is happening to them at school (ACLU/HRW, 2009).

Alternative Strategies to Reduce and Prevent Physical Restraint in Schools

> Now that we know that restraints actually kill children each year, we must respond immediately. We urge nurses and all who work with children with mental-health challenges to keep in mind that there are ethical and moral elements to the issues of restraints. Because of fiduciary ethic, the

> principle of benevolence, and the obligation to do no harm, professionals are under an obligation to minimize any unintended adverse consequences of any intervention. The continued use of restraints in circumstances in which less restrictive, more therapeutic alternatives are available to ensure the child's safety or the safety of others violates the principles of beneficence and nonmalfeasance. (Mohr & Anderson, 2001, p. 149)

Alternatives to R/S are very important because they will support the physical and psychological safety and wellbeing of the child and others, reduce painful witnessing by other children, increase the morale of staff through creating a better and safer job environment, strengthen relationships between teachers, parents and administrators and increase the capacity for effective behavior in children. This section will focus on presenting alternatives for new teachers that will encourage the use of class management strategies to promote learning and social-emotional positive environments as strategies for reducing R/S. The approach includes positive behavioral interventions to be used within a wraparound model of care for children with vulnerabilities. The aim of this approach is to improve the school climate for all children, staff, parents and the community.

In a review of the assumptions supporting the use of restraint with children, Mohr and Anderson (2001) suggest that researchers need to explain how institutional violence continues to occur on a regular basis in some settings. They also suggest some guidelines for how to increase awareness of the hazards of restraint use and appropriate alternatives. For example, they argue that it is important to educate staff about the benefits of less restrictive methods of intervention over more restrictive methods. It is also important for staff to be aware of evidence of short- and long-term consequences of restraint use. They argue that staff who use restraint should have to demonstrate that the restraint response is happening as a consequence of an emergency or unforeseen event and is being used

because the preventive framework has not adequately contained the misbehavior. They suggest that researchers can support these efforts by evaluating well-documented practices such as peer-delivered services that are proven to have reduced or eliminated unnecessarily restrictive measures. A more broad approach advocated by the researchers is for schools to actively promote a philosophy that is supportive of interventions that are non-aversive. As they state, "Interventions in which children deliberately are subjected to pain or discomfort are unacceptable, regardless of whether they are effective in reducing undesirable behavior" (p. 141).

There should be well structured training of staff at all levels on a regular basis with the intention to develop non-aversive strategies. For example, positive behavioral support interventions involve transforming the undesired behavior into proactive behaviors. Ongoing conversations conducive to planning for a systemic change will be important as a way of reviewing the guidelines that govern the use of R/S and other aversives. These conversations should include committees that are made up of families, underrepresented groups, community stakeholders and governing representatives. They should include people from different disciplines who can give different perspectives. Mohr & Anderson (2001, p. 141) cite Donat's recommendation "to obtain mandatory consultation with a behavior modification specialist in cases of high R/S utilization in inpatient settings."

A public health model suggested by the National Association of State Mental Health Program Directors (NASMHPD, 1999) that addresses primary, secondary and tertiary prevention will be useful to reduce and eventually prevent the need for restraint. The model advocates the practice of early intervention that uses the least restrictive

methods to reverse or prevent negative consequences. Mohr & Anderson (2001) argue that such an approach can contribute to the goal of safer environments.

> The solution is in the relationship between the staff and the acting out person. What makes programs work is when staff begin to have insights about how they're dealing with people. It causes a change in the culture. They change the way they behave towards their clients and, thus, their relationship changes. (Hines, as cited by Morrison et al., 2002, p. 36)

In a 2001 study, Petti, Mohr, Somers, and Sims explored the clinical relevance of R/S from both patients' and staff's perspectives. They analyzed the content and descriptive statistics of debriefing incidents in 81 cases: "A multifaceted program was designed that would commit the entire hospital to a reduction in the use of [R/S]" (p. 116), with strong support from leaders. Staff received a strength-based model to change the deficiency-based model of care. To invite an outside perspective, a parent advisory group started to promote family and community input and to provide input on policies and procedures. The Conflict Prevention Institute (CPI) trained all staff on early behavior awareness and nonphysical interventions, with booster sessions and opportunities for consultation in an intermediate-term care facility. Each R/S incident required a mandated process, and a request was made in each case for a debriefing report that included how to avoid R/S in the future (Petti et al., 2001).

The debriefing procedure consisted of structured interviews in which nurses and others involved were asked to meet with the child that had been subjected to R/S and to respond to the questions about the incident that provoked the intervention. They asked each child for the reason, what preventive measure could have been possible, what alternatives were presented before the incident, if they received their medication, an explanation for the R/S, an explanation for the criteria that was conducive to the use of

R/S and an explanation for release. The staff also asked the child if their dignity and privacy were respected during the process.

After a summary of the data was presented to staff, the number of reported incidents reduced dramatically. In the discussion piece, the authors report that it is very important to use systematic debriefing of critical R/S incidents as a management and education tool. The lessons learned from this study are listed below.

(1) Precise language/recordkeeping: The authors argue that there is a need to educate staff to describe behaviors and incidents precisely; for example, "aggressive behavior" does not help children learn what the behavior was. Instead, descriptions such as "biting" and "slapping" are more helpful. They argue that jargon used by professionals impede, instead of support, communication.

(2) The need for more precise assessment: An outcome of debriefing is to collect information that can help to understand antecedents to the R/S incident. An important aspect of this process is to understand the function of the behavior. For example, when responding to behavior by the child designed to promote increased attention on the child, avoidance or sensory stimulation will support an intervention that will, in a pro-social manner, get the child what the child needs. An additional point is that staff, too, use certain behaviors to gain specific ends. In the survey, staff justified safety as the major reason for the R/S; however, children reported that noncompliance and anger were the reasons that ended in the use of the intervention. A possible understanding of this difference is that youth need to have more anger-control training or more social-skills instruction, whereas staff needs more training in verbal mediation. Efforts to identify the antecedents, behaviors and consequences of restraint use may be labor-intensive but the

authors stress that only an accurate assessment is capable of promoting better understanding.

(3) The need for education and cultural change: Petti et al. (2011) conclude that, "Virtually all the theoretical and empirical literature on cultural change within organizations agrees that such change does not come easily or rapidly" (p. 124). In order to change behaviors, an attitudinal change needs to take place. Changing the existing culture by using cognitive reframing and the use of data informed by monitoring behaviors may gradually lead to trained staff and patients having an attitude that fosters a prosocial behavior. (4) The importance of tracking patient progress over time: An important component of tracking patient progress over time is to use indicators that can be quantified and that are unambiguous. While not a perfect solution to capture the whole story, the use of quantifiable indicators is a good start because it makes possible the collection of data that can help measure change. Debriefing records contain relevant sets of indicators and can be verified. By documenting each incident, trends can emerge and progress can be measured. Such documentation can support decisions of when to modify treatment procedures.

(5) The use of debriefing as a feedback mechanism for the maintenance of new staff behaviors. While it is difficult to create and maintain institutional cultural change, a systematic debriefing process permits data collection of cross sectional perceptions that can shape behavior: "The challenge to eliminate restrictive practices except when absolutely needed requires systematic study of the process and structure of S/R use and efforts to effect change. Hypotheses must be generated. Issues concerning S/R are complex and emotionally charged" (Petti et al., 2001, p. 125).

The Substance Abuse and Mental Health Services Administration's Administrator, Charles Currie, concluded that, "Seclusion and restraint should no longer be recognized as a treatment option at all, but rather as treatment failure" (United States Department of Health & Human Services, Substance Abuse and Mental Health Services Administration, 2003, para. 6). The Pennsylvania Department of Public Welfare took this approach in an aggressive program in 1997 that successfully reduced incident of R/S, as well as the number of hours patients spent under those techniques. Their key principles (as cited in Morrison et al., 2002, pp. 34-35) are listed below.

> Seclusion/restraints are safety measures, not therapeutic techniques, which should be implemented in a careful manner; seclusion/restraint are exceptional and extreme practices for any patient. They are not to be used as a substitute for treatment…; the treatment plan includes specific interventions to avoid seclusion/restraint…. Finally, there is a need for all first responders to be trained of the risks of prone restraints due to positional asphyxiation; training should also present interventions for reduction of death and dangers of prone restraints. (Morrison et al., 2002, pp. 35-39)

In the 2003 article, *Practicing Restraint*, Kirkwood writes about Stromberg and LeBel's research on the use of restraint with children in different institutions (More Harm than Good section, para. 9-14). These researchers found that the New York Bellevue Hospital's psychiatric unit staff was committed to doing whatever it took to see a child through a crisis by talking through the situation. They also discovered that this institution is known to be a place "where restraint is not used at all in the child unit, and only rarely in the adolescent unit" (More Harm than Good section, para. 11). They observed a situation where a young girl was hitting a wall. A nurse validated the girl's feelings of anger, took the other children out of the room and created a quiet environment. With these moves, the situation rapidly diffused. Both DMH officials worked very hard to

identify the elements that correlated with the reduction or elimination of restraint use. They explored the number of staff, trainings and salaries in order to find the key to what allowed the institution to be restraint-free. They did not find a single cause. They continue: "But there was crystal-clear, rock-solid leadership [committed to finding another way], and a group of people who understood they could negotiate any kind of crisis without resorting to restraint" (More Harm than Good section, para. 13).

Stromberg and LeBel (as cited in Kirkwood, 2003, More Harm than Good section, para. 14) used that model by training, visiting that hospital, connecting agencies and educating on best practices and were able to create a change in Massachusetts where "after just 2 1/2 years, the use of R/S was down 78% in licensed child facilities across Massachusetts, 65% in agencies with a mix of child and adolescent services, and 44% in adolescent service agencies" (More Harm than Good section, para. 14). Some of the alternatives presented in this article are: to have a philosophical change, to be able to find better ways and to be able to relinquish control: "All models of recovery are based on empowerment, self-determination, collaboration, partnerships. The more control an agency yields to its residents, the more opportunity for growth" (Huckshorn as cited in Kirkwood, 2003, Relinquishing Control section, para. 5).

Another cultural element has been identified concerning children with disabilities. The ACLU/HRW (2009) found that:

> Students with disabilities—who are entitled to appropriate, inclusive educational programs that give them the opportunity to thrive—are subjected to violent discipline at disproportionately high rates. Students with disabilities make up 19 percent of those who receive corporal punishment, yet just 14 percent of the nationwide student population. Human rights law protects students with disabilities from violence and cruel and inhuman treatment, and guarantees them non-discriminatory access to an inclusive education. Furthermore, as President Obama noted

> when signing the UN Convention on the Rights of Persons with Disabilities on July 24, 2009, US law has attempted to ensure that children with disabilities were no longer excluded and then no longer denied the opportunity to learn the same skills in the same classroom as other children. Yet in countless US public schools, students with disabilities—who already face barriers to attaining a quality education—face physical violence that further discourages them from reaching their full potential. (pp. 2-3)

Alternatives to physical restraint should be targeted for all students, including students with disabilities. As the ACLU/HRW (2009) state:

> Students with disabilities—like all students—need safe, secure school environments in which they can effectively learn. Corporal punishment cannot function as part of that environment: it causes pain, injury, and degradation of the student's medical condition and it is ineffective. Best practices for school discipline for students with disabilities incorporate many of the same techniques as best practices for students without disabilities. (p. 5)

Positive Behavioral Interventions and Supports (PBIS) is a proven framework that allows educators "to respond to each child, teaching them why what they did was wrong and how they can correct their behavior" (ACLU/HRW, 2009, p. 53). In this section, PBIS is at times called PBS. Sometimes, when the approach is tailored school-wide, it is called Positive Behavioral Interventions and Supports School-Wide (PBIS-SW).

The Department of Education Office of Special Education Programs (OSEP) and the Department of Education Office of Special Education Office and Rehabilitative Services support nationwide changes in the use of restraint in schools. Their policy is for educators to move towards PBIS for students with and without disabilities as a way of creating effective school cultures. They argue that such an approach constitutes an improved means of responding to the underlying reasons for the child's misbehavior; furthermore, it is consistent with the school's mission of education.

Within this structured environment, children can change their behavior and return to class ready to learn. School-wide PBIS is a systems approach for establishing the social culture and individualized behavioral supports needed for schools to achieve both social and academic success for all students. It is based on evidence-based research. Positive Behavioral Interventions and Supports School-Wide (PBIS-SW) defines and teaches positive social expectations, acknowledges positive behavior and establishes consistent consequences for problem behavior.

PBIS-SW bases its decisions on regular on-going data collection, is part of a continuum of intensive, individual interventions and requires administrative leadership and a team-based implementation towards effective practices. The PBIS-SW approach advocates for changes that will benefit children's academics, promote parental involvement, lower discipline referrals and risk factors and increase protective factors. It is argued that staff will also benefit from this approach. The intervention supports improved consistency of response across faculty, support greater collaboration in support of individual students, improve management of the classroom and routines, provide strategies for preventing and pre-empting problem behavior and reduce faculty absenteeism. Some positive effects discussed in the PBIS site are that it improves student behavior, increases retention of staff, improves substitute performance/perception, increases ratings of faculty "effectiveness" and supports staff's perception of competency. The above outcomes all happen, the authors argue, because PBIS provides tools for planning and provides effective strategies for addressing problems (OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports, n.d.).

Positive Supports that encourage learning and successful strategies for students, teachers and school administrators, foster academics, improve learning environments and help the social and emotional development of children while adding to the staff's sense of capacity and competency. ACLU/HRW (2009) support the belief that students with disabilities can benefit from such supports and the PBIS approach encourages best practices.

For example, IDEA makes the argument that when identifying risk factors:

> As reviewed in a recent report by the Congressional Research Service, the IDEA provides that when the behavior of a child with a disability impedes the child's learning or the learning of others, the IEP team must consider "the use of positive behavioral interventions and supports, and other strategies, to address that behavior." Positive behavior systems create environments where rules and expectations are clear and consistent, are understood and accepted by everyone in the school, and are reliably enforced. (ACLU/HRW, 2009, p. 54)

Horner and Sugai (2009) report that using PBIS-SW in more than 9000 schools across the US has resulted in the reduction of problematic behavior and improved academic performance. The authors argue that although intensive support for individual students' behavior is effective, it is inefficient, and they point out that it will not be necessary to have such a high level of support once the PBIS-SW approach is implemented. They also note that non-experimental evaluation has indicated that the PBIS-SW approach reduced the number of instances of restraint and seclusion and increased the impact of interventions to promote prosocial behavior.

In the United States, 46 states are using the PBIS-SW model at three levels of implementation: universal (for all students); secondary (targets students at risk); and tertiary (intervention for specific students with patterns of problem behaviors). The

ACLU/HRW demonstrate the effectiveness of the program in statements such as the following:

> The Centennial School of Lehigh University, which provides educational services for children classified under the IDEA as emotionally disturbed or autistic, implemented PBS and went from having over 1,000 restraint incidents per year to having zero restraint incidents and zero "seclusionary time-outs." (ACLU/HRW, 2009, p. 54).

When a child's behavior is in the way of his or her learning and of his or her peers' learning, research may provide tools that will support putting skills in place for the child to have the opportunity to be successful. Those additional skills will support not only the child, but will positively impact his or her environment and will generate pro-social skills for the child and others: "Positive behavioral supports used research-based strategies that combine behavioral analysis with person-centered values to lessen problem behaviors while teaching replacement skills. These proactive practices teach children to build social relationships and skills they need to progress to adulthood" (Butler, 2009, p. 3).

The NDRN suggests best practices for implementing PBS and reducing the use of R/S in schools. They argue that it is necessary to have a commitment from the leaders and decision makers to adopt the framework and support policies that will ensure the intervention will function. Such policies would ensure ongoing training of personnel, the prevention or de-escalation of a situation where restraint might be used and the involvement of parents when planning behavioral management for each individual (NDRN, 2009).

Concerning planning, the National Technical Assistance Center (NTAC) has a copyrighted tool called *Six Core Strategies to Reduce the Use of Seclusion and Restraint*

(Huckshorn, 2005). The NASMHPD presented an informational tool with rich resources that will be further explored in the guidebook, and created a curriculum based on those six core strategies designed to prevent R/S. These strategies include: (1) leadership to create organizational change; (2) the use of prevention tools such as, individual crisis prevention plans, sensory interventions and tool to assess medical risks and risks of violence ; (3) the use of data to inform practice; (4) the development and support of a workforce; (5) the inclusions of consumers (i.e., youth and families) in the process, and; (6) the use of debriefing methods to prevent reoccurrence if R/S occurs. This tool and the information in this section will be an important resource for the creation of the guidebook.

The first core strategy is a mandatory intervention requiring clear leadership that will support the development of a vision, values and philosophy as well as the implementation of an action plan that will hold staff accountable. It is recommended that the action plan have a public health prevention approach, and that a performance improvement team or taskforce is implemented in order to support effective change. The administrative leadership will be in charge of oversight of each R/S event and will have to involve the CEO or COO in all R/S events. The CEO or COO will, together with staff, investigate causality and review facility policies and procedures that may lead to conflict. It will also look at workforce development issues.

The second strategy requires the active use of data to identify the baseline and subsequent use of R/S. There is a need to gather data on facility usage by unit, shift, day, individual staff member, victim characteristics and other variables. Additionally, it is important to set improvement goals and monitor patterns of restraint use over time.

The third strategy, workforce development, requires the creation of a treatment environment in which policy, procedures and practices are based on the knowledge and principles of recovery and the characteristics of trauma-informed systems of care. Such an environment will promote prevention and is strength-based. An important component of creating this kind of treatment environment is providing appropriate training for education staff to help their students build their life skills in a way that serves their unique learning style. Staff will also be trained to note students' specific needs and strength-based strategies in their individualized treatment plans. This core intervention communicates to staff knowledge, skills and abilities related to R/S reduction, and this is reflected in all the processes: hiring, interviewing, job descriptions, evaluations, orientation and ongoing activities.

The fourth strategy prevents and reduces the use of R/S based on individualized treatment and tools to mitigate risk and teach methods of self-calming and soothing. The intervention uses several tools and assessments to integrate policy and procedures for each person. This strategy takes into consideration risk assessment, restraint history, trauma assessment and it provides tools to identify high risk factors for death and injury. It provides de-escalation surveys or safety plans, use of person-first language, environmental changes to include comfort and sensory rooms, sensory modulation experiences and other meaningful treatment activities designed to teach emotional self-management skills.

The fifth strategy involves formal inclusion of consumers, children, families and external advocates in various roles and at all levels in the organization. It includes consumers of services in all the processes: oversight, monitoring, debriefing, peer support

and also requires that service consumers play active roles in key facility committees. It also elevates the importance of supervision of staff and volunteers. This strategy provides clearer parameters concerning how to include consumer input concerning issues such as job descriptions, expectations, work hours and effective communication.

The sixth strategy recommends that every single event of R/S be analyzed in a debriefing. It is expected that this strategy will reduce the use of R/S because of the knowledge gained by understanding the events that led up to R/S. Such knowledge will be valuable for policy makers as they work out what procedures are most likely to support the elimination of R/S events. Another goal of debriefing is to mitigate the adverse and potentially traumatizing effects of an R/S event for all involved parties. It is recommended that following an R/S event, the treatment team hold an immediate post-event problem-solving analysis in order to be clear about the reasons for the event, and to establish how to avoid a similar event in the future.

Another way to effectively address challenging behavior from children is to work collaboratively with parents, teachers and other stakeholders to identify and effectively respond to that behavior. Greene (2008) has advocated reducing distress in children through a Collaborative Problem Solving approach. The rationale for using the Collaborative Problem Solving (CPS) approach in schools is that children that face emotional and social challenges are not well understood. Teachers do not have enough opportunities to cooperate with parents, classroom management is very difficult and teachers are poorly supported. Parents, on the other hand, often feel guilty because their children's behavior at school is out of the norm; they also often feel powerless and discouraged by school personnel's lack of understanding and lack of compassion. Greene

(2008) suggests that the gulf between teachers and parents of children with disabilities is not resolved by schools' attempts to manage student aggressive behavior: "School discipline is broken. Not surprisingly, tightening the vise grip hasn't worked" (p. ix). Instead of reducing violence in schools, the zero tolerance policies created the opposite effect. Ten years of research on those polices found that they failed: schools are not safer; students' behaviors are not being well managed; and dropout rates have increased. Greene makes the point that, despite this situation, "Public elementary and secondary schools in the United States continue to dole out a whopping 110,000 expulsions and 3 million suspensions each year, along with countless tens of millions of detentions" (USDOE as cited by Greene, 2008, p. x).

The CPS model is designed to provide a collaborative rather than punitive response to aggressive behavior. It has worked successfully in households, inpatient psychiatric units, juvenile detention centers, residential treatment facilities, and general and special education settings. This model can also be applied in public schools. The model requires three massive shifts:

> (1) A dramatic improvement in understanding the factors that set the stage for challenging behaviors in kids; (2) creating mechanisms for helping these kids that are predominantly proactive instead of reactive; and (3) creating processes so people can work on problems collaboratively. (Greene, 2008, p. xii)

Martin, Krieg, Esposito, Stubbe and Cardona (2008) analyzed patterns of R/S practices in a hospital setting and recorded the data, attending to what happened before and after the implementation of CPS in a therapeutic program working with children and adolescents with aggressive behaviors. The study found that over the course of five years, 755 children were hospitalized for a total of 998 admissions, as some children were

hospitalized more than once. This CPS was a response to the program's worries and concern with injuries related to R/S practices. The hospital wanted to follow the national trend to reduce restraint in clinical practice: "Toward this goal, legislative measures at the federal level have sought to reduce if not eliminate the use of such restrictive interventions" (Martin et al., 2008, p. 1406).

Research of several different reports provided to hospital staff contain the information that 188 deaths were documented between 1997 and 2008 as a direct or indirect consequence of a prone restraint incident. The CPS approach did have as its original goal to decrease restrictive interventions for children and families. Following the positive response from clinicians and families, the hospital's leaders and staff made the decision that restraint reduction was an important step towards optimal functioning of their institution. They write, "CPS is a manualized therapeutic program rooted in cognitive-behavioral principles that was initially developed to work on an outpatient basis with children and adolescents with oppositional behaviors and aggressive outbursts" (Martin et al., 2008, p. 1407). Their framework identifies aggressive behavior as evidence that a child is not able to respond optimally to a situation. The inability may be related to one of five (non-mutually exclusive) pathways for registering and responding to information, namely, the executive function, language processing, emotional regulation, cognitive flexibility and social skills. In this sense, "The CPS model conceptualizes aggressive behavior as the by-product of lagging cognitive skills in the domains of flexibility, frustration tolerance and problem solving" (Martin et al., 2008, p. 1407).

The authors write that the CPS model was used in this institution to identify important social and cognitive impairments and antecedents in order to de-escalate

potentially aggressive behavior and prevent future outbursts of anger. Based on the model, they identified skills that the children were unable to use effectively, such as problem solving, conflict resolution and anger management. They then employed these skills together with the child to address each situation that was leading to out of control behavior, so that the child could learn to use alternatives methods for responding to stressful or ambiguous situations. It is important to note that even after adjustments related to age, sex, and insurance, the authors found strong racial differences: "Black children were more than four times as likely to be restrained or secluded as their white peers; Hispanic children were 50% more likely than whites to be restrained or secluded, although the difference was statistically significant only for seclusion" (Martin et al., 2008, p. 1409). Results found marked reductions in the use of R/S after the implementation of the CPS model. In the next eighteen months, it was noticed that reductions worked more in the restraint area than in the seclusion area, and they suggested that perhaps reducing restraint may be more achievable than reducing seclusion. Given this finding, Martin et al. suggest that a viable strategy may be to focus on reducing restraint first and then address the reduction of seclusion (Martin et al., 2008).

Ruhl (1985) surveyed 178 special education teachers to determine methods of controlling classroom aggression. She found that teachers use two types of strategies to handle children with aggressive behaviors. One strategy is preventive. This includes: classroom rules; points and/or response cost systems; contracts; physical fitness programs; and cognitive behavioral therapy strategies. The other strategy is consequential. This includes: time out; verbal interventions (tension decontamination

through humor and verbal reprimands); punishment (corporal punishment, mediation essay, overcorrection and referral to school office) and direct physical restraint.

The NASMHPD has published an informational tool that provides mental health leaders with resources designed to reduce trauma and violence in institutional settings by reducing the practice of R/S (Caldwell, LeBel, & Huckshorn, 2008). Several resources presented in this tool will be referred to in the guidebook, as they are pertinent for both leaders and additional stakeholders. The tool includes samples, statements, overviews and protocols that support alternatives to physical restraint. For example, the tool includes a policy from a Cambridge, MA, hospital that stresses the need to provide support for children, staff and families in order for effective change to occur. In the policy, the hospital stresses its commitment to "provide and maintain a safe environment for child psychiatric patients and their families while ensuring that care of all children is humane, non-coercive and trauma-sensitive" (Cambridge Health Alliance, 2005, p. 1).

Sensory-Based, Trauma-Informed and Person-Centered Strategies

Some practices have been identified in the effort to explain how mental health systems have been acting to reducing R/S in inpatient units (Hardenstine; LeBel et al.; National Executive Training Institute, as cited by Champagne & Stromberg, 2004, p. 1). Such practices include implementing a person-centered approach, being educated about trauma, and providing multisensory environments. These strategies involve: (1) A public health approach that addresses primary, secondary and tertiary prevention; (2) An approach that is based on the individual, whose needs are listened to and responded to effectively; (3) Trauma-informed care; (4) Individual tendencies and preferences, (5) Sensorimotor approaches; (6) Sensory diet; (7) Individual Crisis prevention; (8)

Application of sensory-based approaches and (9) Multisensory treatment rooms. These criteria will be expanded on to some extent below, in order to provide some indication of their value as tools to reduce restraints.

Concerning the importance of providing sensory stimulation, the authors note, "Health care providers can learn a great deal from consumers if they actively listen and engage in co-creating treatment environments that offer diverse, meaningful, and sensory rich opportunities" (Champagne; Hasselkus, as cited in Champagne & Stromberg, 2004, p. 2). They also state that health care providers need to reflect on how supportive they are in helping consumers to be more aware of their own capacity to manage their symptoms and their emotions.

The authors stipulate that awareness of trauma is critical for optimal treatment. The prevalence of trauma in patients with mental illness due to abuse, neglect, violence and other factors has been reported as high as 90%. Some settings trigger fear and negative reactions because they evoke traumatic memories. Sometimes, trauma is aggravated by the combination of unaware staff and controlling staff. At the minimum, staff needs to know details related to the type of trauma, age of the event(s), perpetrator and description of symptoms related to the trauma.

Concerning the importance of being aware of individuals, the authors note that each person is unique: "The experience of being human is imbedded in the sensory events of everyday life" (Dunn, as cited in Champagne & Stromberg, 2004, p. 3).

Sensory-based care has been found to be important for reducing rising tension that leads to inappropriate behavior. The authors write that incorporating the five senses is an important part of addressing the experiences a person has had, as past events may have

been experienced in multiple ways: “The brain seeks information primarily by directing individuals to look, listen, smell, touch and taste” (Freeman; Thelen & Smith; as cited in Champagne & Stromberg, 2004, p. 3). Furthermore, traumatic experiences are most effectively treated if the sensory medium is consistent with that of the original experience.

The notion of a sensory diet is a term coined by Wilbarger to refer to “the preferred sensorimotor experiences that help individuals function optimally within their environment” (as cited in Champagne & Stromberg, 2004, p. 3). Most people automatically accommodate their sensory diets without even noticing; however, individuals with a history of trauma, mental illness or addiction may not be aware of their own sensory needs. As each individual is unique, it requires learning to determine each particular person’s sensory diet to support it.

Concerning an individual crisis prevention plan, what calms one person may not calm another person, so there is a need to use a plan that is specific to each person’s sensory needs. Collaboration between health providers will create a full range of options.

Nurses and occupational therapists use aroma-therapy and therapeutic touch primarily to diminish pain, to sleep better, reduce discomfort and for relaxation. Secondary uses of therapeutic touch are to decrease anxiety and pain and to improve the healing of wounded areas. The occupational therapy field had been instrumental in making the science, theory and clinical application of sensorimotor approaches a valuable tool to treat inpatient psychiatric individuals. Some methods are brushing, joint compression, and weights, as well as the use of weighted blankets, vests and lap pads.

These interventions, in collaboration with therapy and psychopharmacology, and combined with the individual's preferences, are useful to reduce R/S.

The first multisensory room was developed in 1975 by Hulsegge and Verheul, after occupational therapists in the 1970s created "treatment spaces filled with equipment necessary for implementing a combination of directive and nondirective sensory-based therapeutic exchanges" (Champagne & Stromberg, 2004, p. 5). These have now become important rooms for tension reduction in in-patient hospital settings.

One study evaluated the approaches listed above and found them to be effective in reducing maladaptative or stereotypical behaviors. Another study reported that when patients were performing a task, the approaches facilitated concentration (Champagne & Stromberg, 2004). A 2003 study involved a consumer evaluation of sensory approaches (as cited by Champagne & Stromberg, 2004, pp. 5-6). The study found that 89% of the sensory room sessions produced a positive effect, 10% had no effect and 1% had negative effect. The frequency rates of R/S decreased by 54% and self-reported levels of stress diminished in the majority of consumers. On the basis of their research, Champagne and Stromberg advise that procedures intended to reduce restraint should be developed in consultation with occupational therapists, so that they can be sensory-based (Champagne & Stromberg, 2004).

Additional considerations need to be explored, such as the role of recreation, movement-based strategies, use of gymnastics and athletic activities. These are natural, cost-effective strategies that can support in vivo sensory-based alternatives in school and community settings.

Management of the Classroom Setting as a Protective Factor Against Restraint

Simonsen, Fairbanks, Briesch, Myers, & Sugai (2008) looked at classroom management as a critical area that impacts on students' performance. They conducted a systematic literature search to identify an evidence-based approach to classroom management. Their intention was to provide a more reliable alternative to the existing literature on classroom management based on teachers' reports. They identified twenty practices relevant for effective classroom management. They explored each practice and presented considerations for how to incorporate those practices. Finally, they provided a tool for assessing and evaluating the practices once they were in place, and made some suggestions for future research.

According to the authors, classroom management has three central components: to maximize time for instruction; to provide instructional activities that engage students and support their learning and to proactively manage behavior (Simonsen et al., 2008).

The researchers reviewed recent classroom management texts and created a list of recommended practices that were grouped into five categories: (a) physical arrangement of classroom, (b) structure of classroom environment, (c) instructional management, (d) procedures designed to increase appropriate behavior and (e) procedures designed to decrease inappropriate behavior. From those categories, they presented a framework that supports successful classroom management, this framework suggests to (a) maximize structure; (b) post, teach, review, monitor, and reinforce expectations; (c) actively engage students in observable ways; (d) use a continuum of strategies for responding to appropriate behaviors and (e) use a continuum of strategies to respond to inappropriate behaviors.

The simplest strategy reviewed was praise. The authors state that praise works best when it names the specific behavior being praised. When it is used in conjunction with other strategies, it has a high rate of success. When students were praised for academic behavior, improvements were found in participants' (a) correct responses, (b) work productivity and accuracy, (c) language and math performance on class work and (d) academic performance. Delivering contingent praise for appropriate social behavior increased participants' (a) on-task behavior, (b) student attention, (c) compliance, (d) positive self-referent statements and (e) cooperative play (Simonsen et al., 2008).

Group reinforcement contingencies and token economies are also conducive to creating a better environment because those strategies (a) increased positive and decreased negative verbal interactions; (b) decreased transition time; (c) increased achievement, appropriate classroom behavior, and peer social acceptance; (d) increased student attention; (e) decreased inappropriate behavior; (f) decreased talk-outs and out-of-seat behavior and (g) increased student preparedness for class and assignment completion (Simonsen et al., 2008). Behavior contracts able to define expected behaviors and associated consequences are related to increased student productivity, increased on-task behavior and daily assignment completion, improved school grades and improved student self-control (Simonsen et al., 2008).

The use of a continuum of strategies to acknowledge inappropriate behavior is also presented. The goal is to decrease inappropriate behavior. One strategy can be a reprimand or a brief, contingent and specific error correction in the form of an informative statement. A second strategy is performance feedback; this provides students with data related to their engagement in both positive and negative target behaviors. A

third strategy is differential reinforcement to control low rates of an undesired behavior, behaviors other than undesired behaviors, an alternative behavior, or an incompatible behavior. These approaches consist of various adaptations of positive reinforcement strategies designed to increase desired behavior and decrease undesired behavior. Another suggested strategy is planned ignoring, namely, when a teacher systematically withholds attention from a student when she or he exhibits undesired behavior. Planned ignoring is effective as a positive reinforcement of teacher attention. Response cost is the strategy used when a stimulus is removed because the student presents an undesired behavior. The last strategy reviewed is time out from reinforcement. When an undesired behavior has occurred, time out from reinforcement involves the removal of a positive environment and its replacement by a less reinforcing environment (Simonsen et al., 2008).

Schools Moving Toward Success

Some schools have begun to implement strategies to reduce the use of restraint. Because their approaches have had very positive outcomes, they will be discussed below. The school initiatives come respectively from Pennsylvania, Texas and Arizona.

The Centennial School of Lehigh University is an approved alternative private school, whose funds come from the Department of Education in Pennsylvania to serve students with emotional and behavioral problems. The school is operated by Lehigh University. This school provides education complemented by speech and language services, adapted physical education, support for transitions, curricular modifications and adaptations and additional services if needed. The school serves 80 to 100 students ranging from 6 to 21 years old that come from 40 different school districts. This diverse

population is 76% Caucasian, 13% African American and 11% Hispanic. Students that have access to the school's services have been diagnosed with a disability such as an emotional disturbance or autism.

The school serves as a training site for graduate students in special education and additional school based professions. They use strict professional development and emphasize teaching behaviors through mentor and supervisor modeling to ensure that the graduate students can build technical and professional skills (Miller, George, & Fogt, 2005).

Miller. George, and Fogt (2005) describe how the Centennial School of Lehigh University successfully implemented and sustained research-based practices to reduce restraint. By closing the gap between education and psychology and creating systemic change, they were able to increase the students' prosocial behavior. Their process towards the virtual elimination of R/S involved a structured approach. First, they identified the problem by exploring what characterized restraint use in the school. To this end, they explored the number of restraints being used per day, the attitudes of the teachers and academics concerning restraint use and the expectations the teachers had from their students. Second, they created a foundation for systems change that required assessment of the educational environment, use of evidence based practices, evaluation of the implementation of an effort to reduce R/S and making adjustments as necessary in order to improve outcomes. The school's mission statement was to ensure that students, staff, and parents have a good place to be where they can learn new abilities (Miller, George, & Fogt, 2005) This process required a collaborative approach. They developed an enriched and stimulating curriculum, created a safe, civil learning environment and

established greater partnerships with parents, which contributed to a hopeful environment. Third, they incorporated research based practices that included PBIS approach and other practices such as academic supports, modifications in the curriculum if necessary, additional effort to engage students and increased reinforcement of positive and prosocial behaviors. In order to sustain those practices, they created a system of support, where administrators and teachers worked together and took a team approach to the changes.

There were some barriers to the success of the initiative. Teachers resisted the new approach because they were concerned for their students and their own safety. Miller, George, and Fogt (2005) suggest that focusing on the students' positive behavior did not sound easy for teachers and it was counterintuitive. They write that this resistance was addressed by celebrating small changes that the teachers made, using data to inform the proposals for change and celebrating small changes that the teachers did make as well as the improvement of conditions at the school.

The school was successful, they used data to inform the proposals for change, promoted awareness of all improvements that took place of conditions at the school and they implemented a virtually restraint-free environment. Consequences of the restraint-free environment were that the school's enrollment increased, the school obtained better equipment with the savings created by a safer environment, reducing staff that was no longer necessary because of the changes, reducing R/S and building stronger relationships with parents (Miller, George, & Fogt, 2005).

The Wisconsin Department of Health Services (DHS) with the Wisconsin Department of Children and Families (DCF) issued a joint memo on March 13, 2009

entitled *Prohibited Practices in the Application of Emergency Safety Interventions with Children and Adolescents in Community Based Programs and Facilities*. The memo supported the notion that effects of R/S were detrimental and stated that, "The Department of Health Services and the Department of Children and Families believe that the use of seclusion and restraint are not treatment nor therapeutic" (DHS & DCF, 2009, p. 3).

This precedent was important because it changed standards of care, invited the use of PBIS strategies, focused on prevention, provided technical assistance and specifically prohibited prone restraint, as well as practices or procedures that inflict pain as means to obtain compliance. In addition, the perspective promoted recovery and healing by listening to consumers, attending to trauma and focusing on recovery (Department of Children and Families & Department of Health Services, 2009)

In 2009, The Dallas Morning News published an article by Emily Ramshaw that stated, "The agency that oversees the state schools for the mentally disabled will hire more than 1,000 new workers and drastically improve living conditions at the facilities under a five-year, $112 million settlement with the U.S. Department of Justice" (Ramshaw, 2009, para. 1). This action was the result of a four-year investigation that found civil right violations across Texas following media attention on events of abuse and neglect of children. The federal settlement agreement required an increase in the workforce and the appointment of several independent monitors to oversee the state schools as they implemented the changes designed to improve the conditions of students and to make schools safer for all (Ramshaw, 2009).

The Crisis Prevention Institute developed a curriculum that promotes nonviolent strategies. The curriculum is reported by some school districts as helpful. One example is the Lubbock Independent School District in Lubbock, Texas. The District reported that they were able to reduce restraint by acquiring verbal de-escalation skills that supported a common language and by taking a team approach. They reported that the end result was that both students and staff felt more supported. The school district also reported that training increased awareness about having an action plan and making sure it was implemented. Another school district that reported the useful impact of training was the Lenawee Intermediate Schools in Adrian, MI. These schools agreed that educators felt validated when the use of nonviolent strategies supported educational goals and a sense of safety.

Successful strategies require collaborative approaches. Another example of a school success occurred as a result of the actions of Michael Remus, chairperson for the Behavior Management Task Force, who wrote the recommendations for the legislation passed in Arizona regarding best practices in special education. In 2009, Remus and other members of the Task Force were asked to examine, evaluate and recommend changes concerning disciplinary actions. They developed a list of prohibited disciplinary actions and recommended training for teachers and aides. They also stated there was a need to communicate with parents concerning disciplinary actions (Remus et al., 2009).

The Arizona senate bill number 1197's set of recommendations by Remus and his team included the creation of a PBIS environment, the provision of necessary educational and behavioral assessments and the need to take into consideration social and emotional health supports. Teachers would be trained to implement these new approaches. Remus et

al. recommended that de-escalation techniques be part of the training process and suggested that, at times when R/S were considered necessary, they only be applied by trained personnel. They recommended that parents be informed of the crisis management actions that took place. They also recommended the prohibition of corporal punishment, mechanical restraint and prone restraint because these types of restraint inhibit the student's ability to breath and communicate.

Arizona's Secretary of State, Ken Bennet, received specific recommendations to reform school policies and procedures according to the PBIS framework. The approach was selected because it is proactive, comprehensive and data driven. This initiative is of particular importance because it is consistent with the resources mentioned earlier in this literature review, such as the Six Core Strategies and best practices for classroom management. The approach recommends giving parents access to the school plan and inviting them to give their input.

Furthermore, the taskforce supported the public health tiered intervention model, also called response to intervention model. Recommendations are explicit concerning how to implement crisis management. The use of restraint and seclusion is admissible only as an emergency procedure. It is recommended that when R/S is used, it be monitored by trained professionals, who then write an incident report. The report specifically prohibits prone restraint and mechanical restraint, and it is explicit that only in extreme danger is untrained staff allowed to use restraint. It also prohibits corporal punishment. The taskforce ends its report with a list of resources for training in Arizona (Remus et al., 2009).

Summary

This literature review has covered a range of literature on physical restraint. It has provided an historical overview of the transformation of restraint use in schools from being an accepted aspect of corporal punishment in schools to being regarded in some states as a dangerous practice that should be stopped.

Schools' purpose has changed throughout the history of the United States and children have been educated under different principles depending in part on the political environment, the dominant group in power and the philosophy behind it. At various times, the purpose has been to educate children to keep the religious faith, to promote skills conducive to train future workers, to promote justice and equal treatment of children or to create a forum where children are provided standards, best practices or opportunities for choice. These different orientations have supported school movements such as the Common School Movement, The Progressive, The Desegregation, The Standards, The School Choice, The Equal Opportunity, the New Standards and The New Choice Movements, and each era has influenced how society in the United States has treated its children.

Corporal punishment has been an accepted as a management tool for children even before schools existed; when schools were created, its use moved to the schoolhouse. The purpose of its use has changed with the times. Initially used to sustain the moral order, it became a way to establish hierarchical categories, keep the ability to supervise, create external control or promote internalized control to perpetuate racial inequality. The ethos behind corporal punishment, that force is sometimes necessary for the greater good, has also justified the later development of one of its forms: physical restraint.

Corporal punishment was at one time a subject of political debate; conservatives held that corporal punishment was not a form of abuse and liberals argued that it was. The issue became no longer one of philosophical differences when the public became aware that the use of this technique was leading to physical injuries, lasting physical and psychological damage and even death. Two important additional findings were that restraint techniques were being used more often with children with disabilities, African American and Latino children and that the behavior that these techniques were designed to change did not change or even got worse. Special attention has been placed in the literature on the danger of prone restraint, as its use is related to more than 188 deaths, many of whom were children, during the past 15 years.

In response to the findings that corporal punishment was detrimental to physical and mental health, 27 states joined the effort to be free of corporal punishment in their school system. However, and perhaps because there is no federal legislation against corporal punishment in schools, 23 states, mostly located in the South and Southwest, still use corporal punishment as a tool to educate children. An important research finding is that that when authorities have had the legal power to inflict force, they have at times abused this power despite being aware of the dangers of corporal punishment.

Some limited literature favors corporal punishment. The few supporters whose writings approve of corporal punishment state that it works, and that the power should be in their own localities to make the decision about its use as a measure of control to maintain discipline. Also, in those states where corporal punishment continues to be used in schools, teachers, unions, administrators and school boards defend the practice despite

evidence that corporal punishment has been responsible for visible physical injuries, and that such injuries inflicted outside of school would not have been sanctioned by law.

Research has shown that physical and/or emotional pain and suffering from restraint is detrimental to the health and mental health of children and also affect family members and other stakeholders. The literature has demonstrated that staff does not always recognize when situations may become violent, and that de-escalations techniques are not in everyone's toolset. As a consequence, sometimes restraint is not the last measure taken and other alternatives are not used even if available. Staff in many settings are not properly trained, and in such situations, restraint is used as a form of punishment to inflict pain.

The emotional damage of restraint use is also a concern. Children who are restrained learn not to trust adults and refuse mental health services. This is a sad irony, since some children who have been restrained will end up with posttraumatic stress disorder, with depression, or will commit suicide.

A strategy to effectively work with children is the Collaborative Problem Solving approach. This approach involves connecting services to provide safer environments for children and a perspective that puts the responsibility on adults to understand and serve well the population in distress. Another strategy is focusing on developing and supporting teachers through classroom management, crisis prevention, de-escalation strategies and collaboration to prevent and reduce the use of R/S in the classroom. Finally, the literature review discusses alternatives to restraint use that are being promoted by some legislators and educational institutions. One potential solution is based on research to implement a comprehensive school approach that includes mental health, occupational therapy, and

social skills in a supportive PBIS environment. It is the belief of those who are promoting alternatives to restraint that schools with pro-social approaches will foster protective, nurturing and responsible caring for children, and that this kind of school environment will promote a form of caregiving consistent with a nonviolent society.

CHAPTER THREE

METHOD

This is a single group nonexperimental formative evaluation method that will involve interviews with eight to ten teachers. The interviews will be conducted either face to face or via telephone. Participants will be asked to provide feedback on an electronic guidebook (Appendix A) that uses a comprehensive approach and is focused on developing and supporting teachers' ability to prevent and reduce restraint and seclusion (R/S) in public schools.

The goal is to gather feedback from teachers on a guidebook that fosters alternatives to reduction and prevention of R/S. Accordingly, they will be asked to respond to the research question: will a comprehensive guidebook for teachers, which aims to reduce the use of R/S in public schools by providing education and skill-building strategies, have a positive impact on teachers, students and stakeholders involved? They will also be asked to respond to the accompanying subquestion: what are the aspects of the guidebook that teachers find most helpful to prevent and reduce the use of restraints in schools? The feedback will be used to improve the guidebook.

The process will require approval of the guidebook by the doctoral committee. Participants will receive an electronic copy of the guidebook. During the interview, they will be asked about the presented guidebook. The occasion of the interview will be an additional opportunity to look at the resources together and to answer any questions from the participants.

Procedures

Soliciting Participants

A recruitment letter, the referral source contact letter (Appendix B), will be sent to a convenience sample that reflects diverse socio-economic status in urban, suburban and rural settings. The convenience sample consists of schools where the researcher has a personal contact who can advocate for the project to improve the response rate. An incentive of a $20 debit card will be offered to each participant as an appreciation for participation in this project. The participant will receive this card at the end of the phone or in-person interview.

A recruitment letter will notify potential participants of the study. It will inform participants about the purpose of the study, its risks and benefits and the right to withdraw at any time during the process. It will ask participants to identify their interest and to contact Nancy Macias-Smith at (617) 930-2009 or at Nancy_Macias-Smith@mspp.edu specifically for the purposes of this study.

Enrolling Participants

A criteria for selecting participants is that participants must be teachers who are, by the time they complete their education, 22 years of age or older. Participants that contact the researcher will go through the process of qualification, using the instrument for phone contact with participants (Appendix C). Qualified participants will get an informed consent form to read and sign stating that they agree to the terms of the study (Appendix D).

Instructions to Participants

The participants that call and/or email the researcher will be instructed by the researcher concerning the time and place of the in-person interview or phone call interview, as well as the details of the informed consent forms they will sign. A phone or

in-person interview will take place (Appendix E). All participants will be made aware of the interview process, including all written material handled and viewed by the interviewer and a transcriber. After the interviewer is confirmed, an email with an attachment of the guidebook will be sent and a time and place for the interview will be set by email and/or phone. The transcriber will be asked to sign a confidentiality agreement.

Data Collection

The audiotape of the interviews will be transcribed by a professional transcriber, who will not have access to any identifying information except the code numbers assigned to each participant. Once the interview is successfully audio taped and all materials transcribed, and the doctoral study is accepted and approved by the Massachusetts School of Professional Psychology, the interview protocols including the audio tape, demographic questionnaire, written interview notes and transcriptions will be destroyed by the researcher between eight to twelve months after the interviews.

Coding Data

To code data, a thematic analysis will be conducted by the researcher. When the coding is completed, the themes that emerged will be examined and labeled to create broad categories. These extracted themes, as well as the demographic data, will be organized and reported in the Results chapter.

Data Storage

All paper copies of such data will be stored in a locked box to which the researcher will have sole access. All consent forms and demographic data collected on paper will be kept in this box along with the original discs used for recording the

sessions. Digital copies of the audiotaped interviews will be stored on a separate flash drive or CD-ROM disc and encoded with a password, and password information will be secured.

Debriefing

Upon completion of the interviews, I will be available to talk with participants wishing to discuss the process further. If any participant during the research process experiences distress from the interview and wants a referral for counseling services, the participant will get a referral to local mental health services and information/resources will be provided.

After the doctoral study is approved and accepted by the Massachusetts School of Professional Psychology, the researcher will be available to discuss the results of the study or will send a written summary of the findings to any interested participants. This summary will be a brief document of approximately four to five pages highlighting the themes of the study. Participants will receive this feedback in a telephone conversation or the document will be mailed or sent electronically or in any combination preferred by the recipients.

Protection of Participants / Ethical Considerations

To ensure that participants' identifying information is fully protected, each participant will have a code to be used on all written materials and audiotaped interviews. Any personal information will be redacted from any documents shared with the transcriber. To avoid any harm to the participants or unintended distress, all materials related to the interview portion of this research project will be encoded with a password. That password information, as well as any related written materials, will be stored in a

locked box kept in a secured location at the researcher's personal office. To prepare for the semi-structured qualitative interview, participants will be given an inform consent (Appendix D).

Proposed Data Analysis

All demographic data will be categorized and reported in descending order of frequency. Interviews will be coded and categorized under broad themes extracted on an after-the-fact basis. The intent will be to examine the utility, satisfaction, clarity and suggestions of the guidebook.

Following the thematic analysis, a discussion of the results and pertinent recommendations for further study and implications for clinical work will be presented in the Discussion chapter of the doctoral project.

CHAPTER FOUR

RESULTS

> You have to be like a hawk, like a scanner. A good teacher has to be scanning, constantly, to have to be aware of the child's need, what makes them tick, in other words. You have to give'em 100 percent in letting them know that you're there, that you care. Once that child, the parent, and the staff and everybody's involved in letting that child know that you care and that you're there for them, I don't see the need of restraining because they'll feel assured that it will not happen. They're willing to work. They're very special. They have to *know*. If you don't let them know that they're special and you're there for them, nothing will work. Nothing. Okay? (Teacher, "Sophia", personal communication, 2012)

The purpose of this chapter is to summarize the feedback on the guidebook that the participants in the interviews provided. The purpose of the interviews was to collect information from teachers on the usefulness and relevance of the guidebook, "Developing and Supporting the Teacher's Ability to Prevent and Reduce Restraint and Seclusion (R/S)". In order to protect the identity of the teachers that participated, each teacher was assigned a fictitious name and all identifying information was excluded. This researcher organized the data thematically based on the questions asked.

Participants Demographics

A total of ten teachers were interviewed. All interviews were conducted in English. The teachers participated from three different states (CT, PA, and MA) and worked in rural, urban and suburban settings. Six interviews were conducted face-to-face (MA) and four interviews (PA, CT) were conducted by phone.

Responses to the 21 questions used in the interviews (Appendix E) were organized into themes based on the following categories:

1. Changes on views of R/S (Questions 1, 15)
2. Utility (Questions 3, 4, 12)

3. Satisfaction (Question 5)
4. Teacher's feelings and emotions associated with R/S (Question 18)
5. Overall impression, feedback on the cover graphic and additional thoughts (Questions 2, 6, 7, 8, 9, 10, 13, 17, 20, 21)
    - What is clear
    - What is unclear material, and what needs to be improved
    - Alternatives to handle aggressive behavior
    - Additional features recommended
    - Benefits of restraint- and seclusion-free environments
    - Barriers to implementation
    - What will help to reduce R/S in schools
6. Suggestions and recommendations (Questions 6, 11, 14, 16)
7. Dissemination (Question 19)

The following chart provides information on the numbers of years that each teacher has been teaching and the school setting (public, private, charter). It reports on the school level (pre-school elementary, middle or high school) and also identifies the setting (suburban, urban, rural) as well as the relevant state or states in which they are or were teaching.

Table 1

Participant Demographics

Pseudonym	# of years teaching	Public, private, or charter school	Pre-school, elementary, middle or high school	Urban, suburban, or rural and state
Julia	1st year as a kindergarten's head teacher. Previously, a teacher's aide for 10 years.	Public school	Elementary	Suburban MA
Luisa	7 years	Public and private schools	Elementary and middle	Suburban MA
Judy	36 years	Public school	Middle	Rural MA
Peggy	11 years	Private school	Elementary	Urban and suburban PA
Lucile	13 years	Private, public, and charter schools	Elementary and middle	Urban and suburban NY and MA
Sally	5 years	Public school	Elementary	Urban MA
Sophia	37 years	Public school	Elementary and middle	Urban CT
Meghan	40 years	Public school	High school	Urban CT
Charlotte	4 years	Public school	High school	Urban CT
Nelly	25 years	Private	Pre-school	Urban MA

The researcher used a convenience sample and targeted public schools. She initially sent emails to school personnel that the researcher knew in several districts

across the country and the researcher attended a prevention of R/S meeting. She also met with education and mental health leaders and gave them contact information; after the meeting, the researcher followed-up with them via email. Additionally, emails were sent to personal and professional contacts with a follow-up phone call. The researcher attempted to recruit male teachers. However, only females responded to the request for interviews. The researcher called and sent additional emails to male contacts hoping to find positive responses, but they did not respond. One rationale is that the interviews took place in May when most teachers were very busy with end-of-the-year work and celebrations; another is that outreach to males was smaller due to the researcher's contacts and the higher proportion of female teachers.

Changes on Views of R/S

Teachers' responses to the question concerning whether reading the guidebook had changed their views of R/S were variable. Responses included no change, the manual affirmed their existing views, slight change and definite change. The most forceful response was from Sally, who mentioned that she was very familiar with the content and that the guidebook did not change her views at all because she was a first responder. Another forceful response was from Luisa, who said that it did change her views. Most responses, however, were in the middle. Judy said,

> It hasn't changed my views but it has validated the fact that I actually am a passionate advocate of responsive classroom and when I got towards the end of your document I realized that you were familiar with it. In the first few pages I am thinking Oh I have to tell her about responsive classroom, I have to tell her about it, and then I realized that you were familiar with it. I just am such a strong advocate of being proactive rather than reactive and I think that this whole document addresses that in various ways that educators can do that. So it did not change my views, it kind of reinforced how I felt like a teacher.

Along the same lines, Julia said, “It has supported my views, it’s nicely laid out. I feel like is very important to have these issues given to teachers. And it is very specific done nicely.”

Peggy mentioned,

> It has changed it a little bit, but I wasn’t very familiar with it because the schools I work with, there are not many children that need to be restrained. I found very useful the guidelines for how to support, you know, how to support these children. You know, how to manage the behavior. It made me realize that behavior management is very important, and the teachers, they need to be more responsible about how to manage this control in the classroom so that there is, the children feel more comfortable in their certain routines and guidelines for the children to follow. So I found, especially the guide on how to do this very useful.

Charlotte, who works with high school students with identified emotional problems, said that she was familiar with the content because of her work in the high school.

Luisa said that the guidebook did change her views on R/S. She responded, “Yes, in the way that I think in school they need more tools and help how to reduce restraint and seclusion with the kid.”

Utility

All ten participants found the guidebook valuable and identified it as a useful tool, for themselves and others. They said that it was easy to read, the content was helpful and well connected and the definitions were helpful. Perhaps the following quotes from Julia and Lucile summarize the overall response. Julia mentioned that,

> It’s very easy to understand because I’m a teacher, and I was an aide and a behavior therapist, so I'm very familiar with the information, this added information that I didn’t know of. So I found it interesting to read. It would be a good resource for teachers to read because it really supports how they feel, especially with the cases that you’ve laid out there, because

> I'm one of those teachers who deals with these issues. And I don't have support of my principal.

Lucile said,

> Well, I feel like this guidebook really does provide an opportunity for educators to think about the many aspects of their roles in the classroom. And so, you know, I think you mentioned teachers as collaborators, and then who are the people that we collaborate *with*, sort of teachers in a larger system or context. You look at the teacher within the classroom environment where they are both collaborators with the students, but also have to be very aware and attuned to each of their students in being able to read, or interpret behavior and language, and behavior being, I mean, language being both verbal and body language. And so I like the way that those different aspects of the teacher's job gets addressed in this guidebook because I think that's an important, that we have to have that level of flexibility when we're working with kids.

All ten teachers also said they thought this resource would be helpful for others; however, some diverged on the target audience. For example, some said that it would be great for new teachers while others said it might be too complex for new teachers. Additionally, Lucile thought this resource would help both teachers who use these procedures as well as teachers who do not. She explained,

> I recall from my classroom days, I was not the person who restrained students because the teacher needs to maintain a positive relationship with her students. And so there was someone outside of the classroom who worked with behavior and discipline, who would come in and if children needed to be removed from the classroom, they did that job. And I think that as school cultures and school communities sort of look at and consider classroom management, and proactive behaviors--both on the teachers' behalves and on the behalf of their students—this tool would definitely help to sort of shape and influence attitudes about discipline, working with children in ways that garner and continue to build confidence and self-efficacy and self-esteem. And I think that those are important components to creating environments where children feel comfortable, safe, and like they can be full participants in that setting.

Sophia said that new teachers would benefit because the techniques presented would support the teachers' goals. She explained, "Inexperienced teachers can become more aware, and learn ways to approach the defiant child."

Satisfaction

All ten participants reported they were satisfied with the guidebook. Most reiterated that they found it easy to read, that it was encouraging and that teachers were valued and perceived from a strengths-based perspective. Judy said that she appreciated the available resources and she was satisfied with the information and resources. She acknowledged that the document allowed her to see the violence that was taking place and to say to herself "Oh, I am not imagining this, this really could be happening in my classroom." Luisa rated her level of satisfaction with the guidebook as a ten on a scale from one to ten. Charlotte and Nelly also used a scale and rated the resources as an eight. Most participants found the guidebook enjoyable and interesting, and they appreciated the new information presented. Julia mentioned, "I found the whole thing was very nicely done, and interesting to read, and very affirmative, affirming me as a teacher. It felt good to read it because I felt like someone was thinking of me, thanks."

Lucile stated she was satisfied with the strength of the many components. She also liked the broader perspective of the guidebook. However, she struggled when imagining how she would incorporate it into the classroom. She reported that she would need more information on how to apply the knowledge with her students and their parents.

Sally said that, as an R/S trained responder, the guidebook was not necessary for her. However, she thought that the guidebook was general in scope and, thus, more

appropriate for administrators who could educate teachers on the specific techniques and de-escalation strategies included in the manual. Sophia said that she was "very happy" with the resources and that it would be important to use it as a reference and to incorporate its techniques for teachers, parents, administrators and other personnel involved with children.

Most teachers welcomed the case scenarios and thought that the examples accurately represented the position of the teacher. For example, Julia said, "I am the same teacher in that case scenario. One teacher, its 24 kids' behaviors and no support." They also said that the scenarios of parents and children were realistic observations of the people that they knew. Two teachers suggested building upon those scenarios and using the strategies presented in the guidebook as examples of how to apply the knowledge that is being shared. One teacher said that her work is in a high school, so she would appreciate examples that address older children and not just elementary age children. An important observation came from Meghan, who said,

> And a little thing, a suggestion, is just be careful when only using the Hispanic surnames. One might think it's a little discriminatory. You know how these people are, and because children of all ethnic backgrounds have these problems, you know? Instead of using the Spanish name, change to John, or Jimmy or Sekuan, you know what I mean.

Teacher's Feelings and Emotions Associated with R/S

Every teacher mentioned that reading about R/S elicited difficult feelings. They mentioned guilt, shame, and sadness. Another layer of concern was how to explain an R/S event to the other children in the classroom, because teachers worried about how it might upset them. Julia mentioned, "[It] is sad, it changes the classroom climate and it feels sad; it really feels sad. There is sadness about it." Nine out of the ten teachers had

not restrained or secluded a child in their classroom. Only one teacher has used these procedures. All of the teachers had witnessed situations that involved R/S and the feeling of guilt was a common denominator. Judy said,

> I always felt that there had to have been a better way, and somehow I had failed at not mediating earlier on in the process, or wondering why I had missed the signs that something was going to escalate, I think I always put the guilt on me when, in fact, sometimes it really was out of my hands.

Lucile contrasted her experience as a teacher in New York with her experience working in Massachusetts. She explained that her experience with R/S in New York was easier for her and worked better because the approach was collaborative between the principal, the teacher and the child. However, she said her experience with R/S in Massachusetts had been more difficult. For example, she believes that the school lacked the available tools and strategies, and this created situations that challenged her own system of beliefs. She explained that she,

> felt bad because my motto had always been *I am your teacher. I get paid to educate you, and I get paid to take care of you and be here for you when your parents cannot.* And so in my own head, I wasn't living up to that. I felt like I was failing my students. And so that was very hard for me. And when I did first witness a kid being restrained, it was traumatizing. I had a mixed, there was just such a, there were so many emotions going on, and I couldn't process all of it 'cause I had to process with my students what we had all witnessed, and I didn't want to be blaming of the kid, and I couldn't understand, I didn't know what was going on for the child. And it was a very, it was a very difficult, stressful time.

Peggy expressed her concern about being open with her feelings regarding R/S inside the school system. She said she felt unsupported by parents and administrators and even considered the possibility that she might lose her job if she openly expressed her frustrations. In her view, the school's expectations of teachers are unrealistically high. She explained,

> You're supposed to be perfect, to their expectations. So you don't want anybody to know that you're frustrated. You know, it might say something about you not being a good teacher. So you don't want to be exposed to that. You don't want to lose your job or, you know.

Sally, a first responder who has experience using R/S techniques, said that she noticed that debriefing was part of the guidebook and she considers it an instrumental part of the process. She explained that, in her school district,

> the staff *have* to debrief after the restraint, and we do that every single time, in a formalized way. And it's all recorded, as well. I don't know if that's common practice, but that's how we did it, and it really worked for us. And, obviously, the staff that are involved—and the staff that know what's happening, but aren't involved—are, we process it for many days. And, depending on the child and how long they're with us, it's something that you're constantly processing with each other. So that's important to do. But then it's also important to close your door, go home, and take a break.

Charlotte said she handles her feelings by thinking about it and talking with the school mental health personnel. She said she talks about it with faculty, with mental health experts and with educators to help her cope with the stress. She added that it is also important to find ways to improve things, to problem solve on how to engage students and how to help them learn because that is why students attend school.

Overall Impression, Feedback on the Cover Graphic and Additional Thoughts

Concerning the overall impression of the guidebook, all ten teachers said they had a positive overall impression. Some adjectives that teachers used to describe their impression included: nice, organized, crisp, clean, well presented, detailed, explicit and descriptive. One teacher stated that most of the information presented was new to her. Eight teachers were somewhat familiar with the topic but still found the strategies and resources helpful. One teacher found the guidebook "generic" as a trained person, but thought that it was a necessary resource for others depending on their familiarity with the

subject. Charlotte thought it was a good resource and provided information for the general population to help them handle students in their classrooms.

Most participants found the cover interesting, intriguing and inviting, but two teachers found it confusing. One teacher recalled that it was the color blue, and the other nine teachers elaborated with different ideas. A few teachers saw a trunk of a tree, and they alluded to collaboration between systems of "branches." Others saw a bird in development on top of the trunk. Lucile saw hands holding up a peace symbol; Julia said that it was a non-invasive image that gave her a "nice feeling." Luisa mentioned that, "The cover of the book, it showed me that parents, teachers, school administration, mental health and the government and the state have to work together. You know, like you build like the web." Sally mentioned,

> I thought it was a medical journal because it looked like tendons, and synapses in like our muscles, or in the brain. So I wasn't sure what it was. But then I figured out they were hands that were touching. So the idea, I think, is good, but perhaps the execution is difficult to identify in my photocopy printout of it.

Judy wondered if a child in crisis drew the image.

Related to the question of which sections of the guidebook were clear, responses included feedback such as: all material was clear, or all material was readable and easy to digest. Individual sections that received positive feedback several times were: (1) Definitions and (2) Roots of Challenging Behavior. The perspective on teachers' strengths and the psychoeducational piece about how to understand how children manage their emotions were well received. Concerning the last item, one teacher remarked that she appreciated that the perspective was proactive instead of reactive. Several teachers found the Massachusetts Department of Mental Health Safety Tool very helpful. In

addition, the Positive Behavioral Support Plan received positive feedback because teachers thought that they could apply this knowledge in their classroom.

Concerning the question of what material was unclear and what material needed improvement, some teachers responded that they would like more specifics on how to work with parents and how to communicate well with them. One teacher mentioned that the PBIS examples from the Blackstone Elementary School were too specific to that school and she was unable to relate to them. One teacher said she needed more details on what to do if a child was beyond the de-escalation phase.

In response to the question about how teachers use alternatives to handle aggressive behaviors, Sally mentioned that it was important to disengage when students exhibit attention-seeking behaviors in order to eliminate the behavior.

Sally also mentioned the importance of language when handling difficult behaviors. She said,

> The way that adults speak with children has such a profound impact on their behavior—that's the piece of behaviorism that I find most interesting. And what and how you say something is one of the most effective pieces of your behavior management, more so than any environmental change. And it allows you to create that community you need, but it allows you—excuse me—to make a change in a moment, and have them, faithfully, understand and be okay with it, even if it's different from what you've set up as standard in the community. So I think more teachers need to learn *specific* techniques about how to talk with children. Here's a silly example. Some of it contradicts what was said in here, actually. It talks, in here, about giving, asking a child to do something instead of telling a child to do something. But behavior research has been showing that when you offer choice—when you don't really *want* them to have a choice—you're giving them an opportunity to resist, and say, "No, no thanks, I'm not going to." So if you want a child to sit, instead of saying, "Can you please sit down?" That's like they can say, "No" because you said, "Can you?" But if you say, "Please have a seat," you're being, explicitly clear, and you're reminding them that their job is to be compliant in a way that's appropriate. I don't know; that's just a silly example.

Meghan believes that it is very important to connect with the children in the first week of school because it is the most important time of the year. She said,

> It is when the student connects with the teacher, and you have to make them feel and to fall in love with you. That's what I think. Make them feel part of your world. Show them that you care for them, respect them, and will always be there when they need you. Show them that they must follow rules in the outside world, and they are called laws. And if you don't follow rules, they must obey the consequences. You're the teacher, you have to teach what's good or bad. That's the thing.

Another example of managing aggressive behavior was talking to the children. Also, Charlotte suggested letting them take a walk under supervision, giving them a break from the stressor—which might be academic work—or perhaps "pulling out" the student that is becoming a distractor in the classroom, and getting support from the parents. Lucile said that when she got her Master's in Education she did not learn how to manage aggressive behavior in the classroom and she was ill prepared. Her concern is that this is a serious issue because teachers at public schools have to contend with challenging behaviors. Lucile said she used positive reinforcement because she believed it was very important to build upon the students' strengths. She stressed her point by saying,

> Giving kids jobs is really important, especially children who do have a harder time [with] unstructured times. Once again, it doesn't have to be punitive. But it's about acknowledging that everybody has strength—or has strengths—and everybody has areas where they need to develop. And I try to come from the approach of a very strengths-based. I'm going to work with the parts that, you know, you feel most competent with.

A few teachers mentioned that it is difficult for teachers to remove all emotion when dealing with challenging behaviors from students. They stated it takes a lot of practice and technique to be able to do so. Sophia said that it is necessary to have an

action plan, a discipline plan and adequate scheduling. She explained that when those strategies and classroom rules are used, the teacher can become "like a hawk, like a scanner."

For the question related to additional features, a few teachers recommended pictures, visuals that they can post, ideas to present to parents and some samples of how the techniques can take action. A few of them agreed that they needed to see a "hands on approach." One suggestion provided by a teacher was the inclusion of a brief fact sheet that teachers and parents could use. One teacher recommended the use of a hard copy guidebook because she found the electronic version was harder for her to digest. One teacher asked for signs that she could post to help the child to calm down and to potentially prevent the use of restraint. She did not specify what kind of sign, but she thought that the visuals could help the child to de-escalate and to regain control. Another idea was a book or a resource that could be specific enough in a particular situation.

One teacher recommended connecting the case scenarios with the rest of the "manuscript" to illustrate how to deal with difficult situations.

For the question related to the benefits/shortcomings of a restraint- and seclusion-free environment, nine out of ten teachers supported a restraint-free policy if possible, stating that it fosters safety and protects the relationship between child and teacher. Judy stated that she thought,

> it's actually a law that, unless you have been trained in restraints, you are not even allowed to touch a student. So that means you can't even put a hand on their shoulder to redirect them to a different location in the room. So you really have to, you have to really prepare and practice with those students. I can't reiterate that enough. I think a restraint-free policy *allows* students to understand that they need to be responsible for their own behavior. The threat of those restraints, I think, limits children's choices.

Peggy said that, with enough people's support and information about prevention, there was a possibility for a restraint-free policy. Julia thought that in her district they did not have any school policy related to a restraint-free environment; on the contrary, she pointed to restraint-use as an aspect of ABA (Applied Behavioral Analysis):

> ABA is very big in our schools, nowadays. And that tends to be the *default* policy, and it's getting bigger and bigger, and restraint comes with that. So I feel like we're losing part of the children's personality because, okay, you look at a child, and he acts up, and he starts moving out of control. If you start with restraint, then you're the big connection, psychologically, with the child. And I see that happen because I worked in a classroom that had a lot of behaviors, and restraint was going on. And it just changed the atmosphere of the whole class, also.

She also said that a restraint-free policy would help children to develop social, academic, and emotional and self-esteem skills.

Meghan said that if students were given the opportunity to have a restraint-free environment, they would be able to express their frustrations, to ask for help and to recall what happened to them. By contrast, students who are restrained cannot relate with others. She also said that when restraint is used, physical injury and emotional trauma can result to both the child and other people involved in the child's life, and argued that R/S should only be used when no other strategies seemed helpful.

Lucile said,

> The benefits of a restraint-free environment are that everyone, every member of the school, that classroom community and that school community can come in and feel safe and respected. Children should not have anxiety attacks, or panic attacks as they're approaching the school. That should be a place, an environment where they feel welcome, and feel a part.

A divergent voice was Sally, who expressed that,

> Restraints are designed to not cause physical injury. And if done properly by trained professionals, that is successful. So I think there, I don't think

> there are benefits to having it be a restraint-free environment, but I understand that it is misused, and misunderstood. And that is absolute key. If a school is going to be allowed to have that as an option, they, absolutely, must be mandated, by all law, to be trained on when it's not okay to use it, which is 99 percent of the time.

When responding to the question of whether they had any personal experience with restraining and/or secluding a child, nine out of ten teachers said that they personally did not restrain and/or seclude a child but had someone else (guard, principal, secretary, police officer and/or nurse) do so if necessary. Sally said, as a responder, she does restrain children. She said that a shortcoming of a restraint-free policy is the potential for personal injury, and she thinks her school district's principal believed someone other than the teacher needed to perform the restraint to save the relationship between the teacher and the student.

Concerning the implementation of a R/S-free policy, some teachers mentioned lack of effective communication, lack of training, and not having enough time because academics are the priority. One said that in her district they discussed the topic and found that it was not a priority at that time. All the participants stated that teachers feel overloaded with work, stress, responsibilities, and "red tape"—an incredible amount of paperwork. Judy responded in a way that summarizes some of her peers' feelings:

> I think the biggest detriment to implementing any new program is that teachers always feel overloaded with work. And they look at it as another, an added commitment that they have. When, in fact, if they were to take the time to learn a little bit about most of these programs, they would find that, in the long run, it actually saves them a lot of time, and a lot of energy, and allows for a much better functioning classroom. I also think that money is a huge issue in most school systems. Budget cuts are always ongoing, and that seems to be, since academics are being so strongly stressed right now, I think the social aspect of education is kind of on the backburner.

As stated above, Charlotte mentioned that in her school they did have this discussion and it was decided that it was not necessary to do prevention. As a result, she said, teachers stopped talking about it. However, in her opinion, this topic needs to be refreshed on a yearly basis. It should be part of professional development because every year, students change, a new generation comes, and personnel change too, making the culture different. Therefore, staff should be prepared to make adjustments to their approach on a yearly basis.

Another concern was that when asked to discuss R/S, teachers may worry about giving the perception that they do not know, that they lack skills or are unprepared to manage their responsibilities. Lucile made this point:

> I do think that in a very general way, barriers to the topic, or discussing the topic of R/S would be that people have to admit that they don't know something. And to admit ignorance, or to admit that you don't have a specific skill, or it could feel like teachers are being blamed, or being judged for not having good classroom management skills. So I think some of what has to be peeled back from that conversation would be issues around shame, as a teacher, or blame and judgment.

Some helpful strategies to reduce and prevent R/S in schools that were mentioned were service presentations by mental health professionals that provide opportunities for parents and teachers to have open dialogue and collaborate on how best to face the challenging behaviors of the child. All responses included the need for teachers' training: a training that is inclusive. Sally mentioned that it was important to have,

> [training] preventative in behavior escalation. But at the same time, the supports that students need— [students] that are emotionally, behaviorally, disturbed, that need more than the typical student—*they* need social skills group; *they* need counseling *in* school; *they* need social pragmatic speech and language support. They probably need sensory and OT. I mean, children who are dealing with this, it's multifaceted, so you have to attack the problem from every angle you can, until you've seen what's working.

Another strategy was to foster training in social skills, a system-wide operation that addresses the problem of inadequate mental health support. One participant stated that in her district they have one psychologist for the whole school, and it was unrealistic to expect this person to be able to cover all the needs of the school. Other suggestions were to use yoga, meditation techniques, and spiritual practices as healthy alternatives for helping children and teachers build skills in stress reduction, which would reduce the use of R/S.

Suggestions and Recommendations

When asked about additional strategies for discipline and classroom management, teachers responded with suggestions concerning collaboration with the family, openness to learn, and improved understanding of the background and health of the child. Other suggestions were modeling social skills for the children and engaging the children in roleplays that invite their feedback.

Nelly said that she never considered restraining as an option in a school, and added, "[If] a school has this policy they definitely need to read this guide to change their point of view."

Meghan said she started the year by telling her students that "[O]ur classroom was their home." She continued,

> [B]ut we were expected to live in a safe and a respectful environment. We would laugh and cry together. At times we would win, other times, lose. And structure was taught. Discipline was taught by being disciplined. Respect at all times. It was my motto.

Charlotte thought the logic and sequence of the guidebook were helpful to her and she could see her and her peers using the resource. However, she said that she needed graphics and comments of older youth so she and others who work with high school

populations can identify with the guidebook. She stated that the strategies, the framework and the logic would all work. However, the case scenarios and the safety tool would not work for high school students. She, therefore, suggested, "Make it somehow more applicable to high school students."

Nelly said that while the case scenarios were relevant, they did not show the reader what to do about the difficult situations they presented. For this reason, the case scenarios should be accompanied by "more in depth strategies."

Using language and understanding how to communicate received special emphasis. One teacher said it was important to be neutral and curious in order to prevent making assumptions about children; it was also important for teachers to learn how to be specific and ask questions. Sally mentioned,

> So when a peer reports an incident, we, immediately, go to the person that they're reporting about to ask questions, never to place judgment, to find out, exactly, what happened. And that is very difficult to determine, regardless of age. But that's my whole job, is to help them negotiate and navigate a conflict, as an outsider—not to do it for them. So I work really hard at teaching them exactly what to say to solve their social conflicts in an appropriate, kind way. And that's a major component of behavior management, is teaching them to be self-sufficient.

Nelly did continue her viewpoint by stating, "Again, if you do not have the option to restrain or to seclude, so you really work with the children, you just work hard for them and for you."

The participants shared the concern that teachers need to have ongoing support from the administrators, parents, and the mental health teams in the school, and they need to be able to have a person to go to when additional support is needed. Some participants indicated that teachers and parents need to be educated about the consequences of using restraint and seclusion. As Meghan said, "As a classroom management strategy, learning

about R/S will reduce its use and decrease a student's problematic behavior. I think the violence, humiliation, fear, and loss of control and anger leads to nowhere. And that's what I believe."

Another strategy is to apply the learnings from available curricula and trainings on the development of teachers' skills. Judy spoke highly of the impact of the Responsive Classroom training on her teaching. She said,

> All my strategies came from Responsive Classroom. And if people are aware of that program, they know that it's basically a program where you help students to understand how they can be responsible for their own behavior, and manage their own behavior, and clearly define expectations and parameters and practice them until students are very clear about them.

Lucile elaborated on love. She said,

> Love, love, love your students. Even the hardest kid has lovable parts and I think that that's something that always helped me, even in my most fragile, vulnerable moments in the classroom. I really worked hard to find some part of my students that I loved. And when we can connect with each of our students around their humanity and human condition, and a place of real genuine caring, I think that can help the teacher and the student journey through the more challenging aspects of their relationships.

Other common concerns were for teachers to have more education in how to manage children with challenging behaviors, for teachers to be educated about how to understand and identify mental health needs, and for teachers to have a broader yet specific understanding of trauma. It was suggested that teachers learn not only about child development, but also about child psychopathology because the lack of education in this area means that teachers do not have the skills to effectively manage the classroom setting.

There were varied opinions on classroom dynamics. Some teachers were specific about the use of incentives like star stickers and parties for good behavior for the whole

class. Some teachers mentioned music, meditation and yoga practices for all children as well as the use of behavioral charts and other strategies to promote a good class climate. However, teachers also expressed their frustration with children coming to school tired, hungry, and "grumpy," as well as other environmental factors that they had no control over.

The participants were asked if the schools disseminated materials related to R/S to minority populations. Most responded that they did not, but that, at times, interpreters were available to support children and families that spoke other languages.

Meghan suggested having more examples of issues that would lead to the use of restraint. She also suggested the guidebook provide more examples of ways to organize a classroom and organize a student's work area, especially students that had challenging behaviors. She provided an example of a student who needed to have a sense of control over his property because he didn't like his things to be touched. She said,

> Even when I used to be a teacher, I would have a little desk, 'Oh, these things belong to Jose. Remember, these are only Jose's things,' because some of them do not even like others to touch their pencils. They liked their specific areas; they loved it that way. They saw that the room was part of their things, like the room in the house. Like the bedroom. Okay?

Sally made the point that the guidebook does not address the issue of the law. She thought the guidebook would have more "weight" in the eyes of administrators if it educated schools on what is legal and in what ways R/S is regulated. She suggested that,

> It would be helpful if there was a section that really laid out, either federal laws, or, I guess, state laws, at least for Massachusetts. Those are important. There are so many protocols involved when you are restraint-trained—with timing, and recording, and reporting that if a school isn't aware of those things, they're—right off the bat—not doing it appropriately. So those are pretty key, foundational basics that need to be preliminary in supporting this prevention and reduction.

Charlotte said that her frame of reference,

> is always prevention, prevention, prevention so I guess until we find out you know what is what gets us to that point then we will not be able to really figure out how to prevent it from happening you know if you have to do restraint or you have to deal with students that require isolation. I mean this is definitely a good way on doing it getting staff to be a little bit more knowledgeable about what to expect and what to do with it, I think that this is a terrific guidebook for that.

She also mentioned that there is a need to find the balance between communicating with and educating teachers and students, and that it was important to have a number of things working together simultaneously.

Dissemination of Future Work

In terms of dissemination and channels for sharing future work related to R/S, teachers responded that they would appreciate having a lecture or workshop on the topic because it connects the material with the practice and helps to put the topic in the "front part of the file drawer."

Charlotte said that most schools have student support services, perhaps with different names, and that these services provide a great channel in school districts for initiatives such as restraint education to take place. Others mentioned professional development opportunities in their school settings. Some participants thought that peer group discussions and teachers' workshops were good places to address this issue and that they could learn from each other's strategies.

Another suggestion was to disseminate information on restraint prevention on websites where teachers talk and discuss as well as on sites where teachers buy school materials. Sophia suggested,

> Well, it could be promoted on the Internet. There are a lot of educational web sites, and with peers, and at staff meetings, even in your district, or

> recommended to other districts. It's a very useful tool. It should be, you know, shared with everyone.

Nelly mentioned other strategies for dissemination. A main strategy for her is to connect with teachers and pediatricians' offices.

CHAPTER FIVE

DISCUSSION

> No child should be subject to abuse in the guise of education. Every child's dignity and human rights must be respected. Abusive interventions are neither educational nor effective. They are dangerous and unjust. Their victims suffer physical harm, psychological injury, and have died. Congress should act swiftly to adopt national legislation to protect children with disabilities. (Butler, 2009, p. 1)

This chapter will provide an analysis of the findings presented in Chapter Four. The chapter will also present the participants' suggestions for improving the guidebook, with the hope that these suggestions will make the guidebook a more useful resource. The chapter will briefly review the research objectives and study design, and will provide an overview of the data obtained from the interviews. Throughout this chapter, the researcher will provide reflections on her personal experience with the topic of R/S, including the profound mark that R/S has made on her and her family's life. She will also provide insight into the connection between the researcher's personal experiences and the teachers' feelings and emotions related to the devastating effects of R/S on children. While the researcher's personal reflections are not the focus of Chapter Five, it is very important to her to have her voice represented in addition to the teachers' comments. These teachers' heartfelt responses provide increased motivation for the prevention and reduction of R/S in schools. The researcher and the teacher are a team because both of them focus on, and care about, the best outcome for the children.

Analysis of the Findings from the Interviews

In general, the guidebook was well received. The level of satisfaction and utility were rated highly according to the teachers' feedback. They enjoyed reading it, perhaps

as a result of their familiarity with the material. The researcher can argue that it may affect the discussion given the homogeneity of the responses.

The teachers did give constructive feedback concerning the quality and utility of the guidebook. From their comments, there are multiple ways in which the guidebook can be improved. Areas of improvement included the case scenarios, targeted activities for older youth, modification of the format, use of applied technology to invite interactivity, and using a delivery channel that attends to adult learning. These are discussed below.

The Case-Scenarios

The case-scenarios need to be connected with the activities and strategies presented in the guidebook. This is important in order for the teachers to see how to apply the knowledge. Connecting the case scenarios explicitly with the other material will provide a model and a support for teachers in their efforts to define an action plan. For example, teachers could use the safety tool in the following way: identify the triggers that may have caused [name of the child]'s reaction.

Another important feedback item is that the case scenarios should identify the children using a variety of names to avoid the perception that children, parents and teachers are coming from a single race or ethnicity.

Schools attend to the needs of children from pre-school until 12^{th} grade and when affected by special needs, some attend school until the age of 22 (National Dissemination Center for Children with Disabilities, 2011). It is necessary in the case-scenarios to provide situations where older youth are involved. If it is decided that the guidebook should focus on younger children, it will be necessary to state this fact and explain the rationale for it.

Targeted Activities for Older Youth

Massachusetts has been instrumental in the prevention and reduction of R/S of children and adolescents. An important contribution that has been made in this area is the recommendation for the use of sensory approaches in disciplines such as occupational therapy, nursing, recreational, music and art therapy (LeBel & Champagne, 2010). This information supports the argument made throughout this research that there is a need for an integrated and comprehensive approach to effectively reduce and prevent R/S.

This researcher would like to emphasize the importance of the role of occupational therapy to support children and adolescents. In her personal experience, occupational therapy services have provided a "voice" to a child that, at the time, did not have one. The field of occupational therapy is successful because it focuses on "the complexity of factors that empower and make possible the clients' engagement and participation in positive health promoting occupations" (The American Occupational Therapy Association [AOTA], n.d., What Is Restraint? section, para. 3).

As a mother of two teenagers that joined their younger brother in some occupational (OT) therapy sessions, the researcher supports the AOTA's statement that OT is a strength-based approach. Occupational therapy facilitates self-awareness and skills development in the areas of personal safety, emotional regulation, self-control, sensory processing, functional communication, health, wellness, and recovery—all integrated in a collaborative approach (AOTA, n.d.). In the researcher's experience, OT has fewer stigmas than mental health services. The researcher has observed that children's perception of the OT space is as a "gym," a place to run in, to discover things

in and to enjoy. Thus, while they use all their tools to develop skills, they do not feel different than typical children when they attend those services.

While not a topic of this research, the use of recreational activities, music and art therapy will also contribute towards the engagement and development of older youth. Rubin (2005) also cites the importance of witnessing the development using additional tools:

> All who work with children in art, have seen many instances of both temporary and prolonged regressions in the service of growth. For the child who finds security in rigid structure and control, this may be seen in a return to compulsively careful work. More often, it is evident in a return to a less structured and perhaps more playful use of materials. (Kramer, as cited by Rubin, 2005, p. 24)

It has been the experience of this researcher that OT incorporates some elements coming from those approaches. It is necessary to stress that schools will need to collaborate with additional systems, perhaps available in the community, in order to coordinate and to provide such services if they are not available in the particular school setting.

Given the feedback of participants that teachers need more "hands on" tools, it will be useful to access some fact sheets and/or informational pages. For example, a series of fact sheets that directly address teenagers from an OT perspective, such as the "20 Ways To Poster Set" from Abilitations (Available from www.abilitations.com).

Modification of the Format

It is difficult to find the right format for adults because learning can be an individual matter. Knowles in the 80s was instrumental in describing how adults learned and differentiating adults' style of learning from children's learning styles (DO-IT, University of Washington, n.d.). Knowles coined the term "andragogy" instead of

"pedagogy" in order to underscore the need to differentiate a curriculum that will engage adults. He argued that adults need to be motivated to learn, to be active in the learning process, and to have their past experiences respected in the learning environment.

Two teachers suggested that the format be modified and mixed. One way of implementing this suggestion is to place the text in two columns, so it resembles a book. Other approaches are to use more graphics and to provide more activities and examples. It was generally agreed in the interviews that the guidebook will be more appealing to a greater audience if it has more visuals, provides more samples, and contains curriculum-like sheets that instructs teachers on how to apply the knowledge in the classroom.

Given the above responses, it is relevant to reflect on the broader question of "How Teachers Learn." Although this question was not explored in this research, it merits mention because teachers are adults and will share a learning style common to adults. As Knowles researched, adults learn in multiple ways that involve at least visual, auditory and tactile senses (DO-IT, University of Washington, n.d.). In the researcher's experience of training school personnel across the United States, teachers are educated consumers that learn using multiple channels. Depending on their level of interest and ability, teachers value books, workshops, lectures, technology, experiential opportunities, cases studies, cooperating with peers in professional development opportunities, generating and creating their own training, and blending and mixing other learning strategies that include their own, as most have curious minds. The reality is that teachers are curriculum developers and recipients, and they want to have a say in their learning.

Blended Learning

One specific recommendation is to use blended approaches in order to capture and to satisfy a broader audience, and to recognize that one method alone may not be the best way to promote the prevention and reduction of R/S. The use of applied technology can foster interactivity by employing a delivery channel that attends to adult learning and provides a hands-on approach.

In 2009, Secretary of Education Arne Duncan said that the US currently had "about 3.2 million teachers who work in some 95,000 schools," (2009, para. 12) and that more than fifty percent of teachers and principals were "Baby Boomers." He was aware that in the next four years a third of them might retire, which means that by 2014 an estimated one million new teachers would be entering the workforce. This predicted change implies a major demographic shift, with an estimate of 100,000 to 150,000 new, first-time hires a year during the next three years (Duncan, 2009). The researcher was not able to find current statistics that support or contradict the Secretary of Educations' predictions. However, it is possible to extrapolate based on the data from the interviews that the workforce is changing and that multiple channels and ways of learning and teaching need to be addressed that support blended learning. New channels of learning include but are not limited to: face-to-face, online webinars, expert presentations, and strategies based on peer-to-peer, mentoring and combined collaborative efforts.

Dissemination

The researcher had the opportunity to interview a range of teachers, from experienced teachers, to some who had several years of teaching, to a new kindergarten teacher. Nevertheless, the range of teachers participating in this research could still be considered limited, and the opinions of the teachers on R/S may not be representative of

the broader population of teachers. In this particular research, most teachers were familiar with the topic of R/S. The researcher cannot help but wonder if teachers that are not familiar with the topic and practices of R/S will find this information useful and applicable to their own experience. It will be important to access a broader audience in order to accurately learn how to make the guidebook valuable and relevant to a broad range of teachers.

Personal Overview of Learning During the Process of Finishing the Doctoral Project

It is very important for the researcher to disclose that the experience of researching the doctoral project humbled her very much, and to share her appreciation of the direction, patience and support of the doctoral committee. The initial goal, long ago, was to be able to access all kinds of leaders, from parents, to mental health professionals, to educators, to teachers and professionals from other disciplines in order to have an open discussion and perhaps delineate a framework for the prevention and reduction of R/S. While an honorable goal, it became clear that it was much too ambitious, given the scope and possibilities of this doctoral project.

In no way is the researcher restraining her passion and respect for working towards the prevention, reduction and even elimination of R/S in US public schools. Her intention is to assess the process that brought her to this point and the learning associated to it. When the research question became less ambitious and more clear, the researcher learned with some joy that serious efforts are made on behalf of parents to reduce R/S. This finding was a new discovery for her, as her experience was that of an isolated Latina, who could not get through the ignorance and barriers of the school personnel in the well-to-do district in which she chose to raise her children. The researcher chose to

buy a house in the area specifically because it was described as a "great school district." At the time, her child with special needs was not even conceived, and she brought to the district two special, intelligent and wonderful "typical" children to the school district and was blessed once more with an equally intelligent, special and wonderful child that happens to require special education because he was atypical.

I have faced a dilemma on how much information to share as a researcher affected by R/S. R/S affected me, my husband and our three children emotionally to the verge of becoming a traumatizing experience for all of us. To this day, the struggle with the school system continues affecting us financially. It requires a significant amount of funds to be able to access child advocates, educational advocates, lawyers, mental health assessments and clinician fees and it requires an incredible amount of emotional energy to support and to stand for our child's rights.

Facing an uncooperative school district is an expensive legal battle that no parent should have to sustain. I am writing the discussion on the side of caution and prudence as I need to protect the privacy of my family. If anything, this experience with the school district made us stronger. They can try to subdue and control us but they will not succeed because we have such strong motivation to fight for the dignity and safety of our children and beyond it.

One of the researcher's experiences from doing this research was to get closer to the efforts of The Council of Parent Attorneys and Advocates (COPAA). She learned how they work collaboratively and support efforts from school teachers, personnel, administrators, and education leaders in rejecting the use of restraints, seclusion, and aversives. This organization supports Positive Behavioral Supports (PBS) and advocates

for the adoption of laws that will keep children safe. They stress the importance of the fact that adults can make choices about where they live and work, and that the law protects them from assault, while children do not choose where they live and go to school and need adults to act responsibility to protect them wherever they are (Sullivan, 2009).

The researcher imagines that a reason for why the participants' responses were so positive is that the states they work in are generally regarded as more "liberal." Reflecting further, the researcher wondered: if highly educated, middle class parents who can afford lawyers and advocates and private psychologists and psychiatrists can be so oppressed, what happens to children and families that are affected by poverty, lack of supports, lack of educations and even lack of skills in English; what happens to the "forever minority"?

Another fundamental issue is the importance of a collaborative approach, and the question is between whom. Teachers, parents, administrators of mental health and administrators of education all potentially play an important role in deciding R/S use. Each cluster has its own strengths and limitations, and all bring to the table different agendas and different emotions. However, the bottom line is that R/S is not a popular subject. There is enough blame around the use of R/S to be distributed across all parties, and the different players do not trust each other. Promoting education on R/S will go a long way towards opening up channels of communication so that the different parties can collaborate effectively with one another. As one teacher said, "prevention, prevention, prevention," and the master of prevention is education.

Based on the responses from the participants it is reasonable to respond to the research question with a statement: the guidebook developed is a helpful support towards the prevention and reduction of R/S in schools.

Incorporating the Suggestions

In order to improve the guidebook, the first step will be to incorporate as many suggestions from teachers as possible and to ask a new set of teachers for their input, perhaps moving towards key informants. One criteria may be that they are unfamiliar with the topic to truly assess the guidebook's benefits and shortcomings.

It is important to recall the six core strategies curriculum, because it taught this researcher that it will be important to focus on leaders and be aware of who the audience is in order to ensure change and success in the R/S education process. In terms of dissemination, there is a need to think carefully about what audience will most benefit from this guidebook. There are many possible target audiences, including teachers in training, newly hired teachers, experienced teachers that can become mentors, and expert peers. It is also important to meet the specific needs of a variety of target audiences using a collaborative approach. The researcher has gained from the experience an appreciation that it is very important to employ a comprehensive approach, in which the different parties feel part of the team.

When an approach is collaborative, the different stakeholders are able to contribute in a way that ultimately benefits all children, and not only those affected physically by R/S. Importantly, this research confirmed that all children are affected by R/S, as well as parents and teachers. Additionally, this form of violence does not develop

skills; on the contrary, it is a seed for trauma and potentially creates the basis for PTSD and other major mental illnesses.

Insights on Common Learning

The researcher appreciates the generous contribution from the ten participants, their time and their lessons. Based on the interviews and the researcher's personal experiences as a parent, attending to the corrobated premise that a collaborative approach is a must to effectively address the prevention and reduction of R/S in schools, some particularly compelling themes are:

1. Many teachers and parents love their children and students.
2. Teachers and parents have a passion for a better future for all children.
3. Teachers and parents hope for a better environment.
4. Teachers and parents suffer the consequences of R/S and they feel sad, frustrated, ashamed, guilty and hopeless.
5. Some teachers and parents are forever changed by R/S, they are overwhelmed by it and some reported to have suffered vicarious traumatization.
6. Teachers and parents can and do their best to change, prevent, reduce and eliminate R/S in schools and all settings because teachers and parents are fundamentally good people with dreams and hopes. Also, they learn and they change because they share the incredible opportunity to make tomorrow a lighter day.
7. Some teachers and parents share the profound marks left by R/S and they connect because they know that progress and freedom are possible.

8. Teachers and parents need to be educated in developing skills and abilities to better support their children and students.
9. Teachers and parents need support from the leadership and to be able to have a voice that authentically represents them no matter what disadvantages they bring to the table (social, educational, financial, language barriers, poverty, disability, trauma and more). Teachers expect their educational leaders to have the best intentions to support them and their students to succeed.

Recommendations for Future Research

Many teachers' voices on this topic are silent as they are fearful of retaliation by their school district(s). For example, in this specific set of interviews, teachers indicated that they felt pressured to have the right attitude towards restraints. Only when the audiotape went off did they feel that they could "really talk," despite the assurance of confidentiality and anonymity throughout the interview. One teacher said that after the researcher stopped audiotaping that she was "terrified" to learn about prone restraints but that she did not wanted to be "officially" recorded making that statement. She (the teacher) did allow this researcher to note her comment in this doctoral project.

Additional research is necessary to learn more about how to help and to support teachers. This researcher has empathy for teachers' feelings of isolation and loneliness, and understands their need to express their fears and concerns. A teacher may be concerned for the safety of her/his job. On the other hand, a parent may be concerned for the child's physical and emotional safety if disclosure takes place and it is not welcomed by the school district.

Classroom management strategies that inform about trauma and mental health will provide teachers with tools to work with children who have challenging behaviors. The researcher had the opportunity to work on training on trauma informed care for an entire school and saw the great need for psychoeducation and tools for teacher to be able to succeed with their students when working with multi-stressed communities.

A collaborative team that makes decisions must incorporate teachers' voices to prevent, reduce and eliminate R/S in public schools. Teachers need to be able to be vocal about their professional development needs and about the skills they believe they need to facilitate their classroom management.

It is recommended to expand research that further engage and include male teachers, in order to get their perspective towards the reduction and prevention of R/S.

A collaboration is needed between mental health and education leaders that will make possible the development of action plans with teachers' input. One possibility is for mental health leaders such as the Massachusetts Department of Mental Health to coordinate with other education leaders on adapting their materials for the purposes of training teachers to support the reduction and prevention of R/S.

Teachers will benefit from being able to access additional research based on existing successful models. Information based on these models should be disseminated in schools across the country

Existing research on affected youth is limited. Additional research is needed so that youth's voices are heard and youth are able to collaborate with other relevant parties towards the prevention and reduction of R/S.

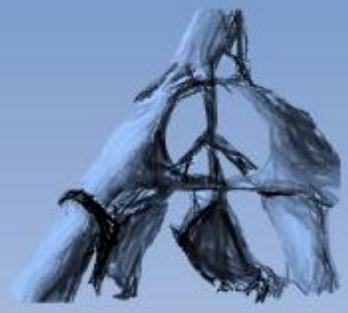
With reference to legal issues, it was mentioned in the literature review that there is no current legislation at the local, state or federal level that would provide the necessary tools to have proper training to support quality standards of practice. Two teachers also stated they were unaware of any such laws. Such laws would include reference to functional data systems, ongoing trainings, culturally competent materials and processes in place that would foster collaborative efforts towards the reduction and prevention of R/S in schools across the United States.

LIST OF APPENDICES

APPENDIX A

GUIDEBOOK

Developing and Supporting Teachers' Ability to Prevent and Reduce Restraint and Seclusion (R/S)



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CONTENTS

Section I.
Introduction

"Nothing else we do in life prepares us to guide a roomful of students on a learning adventure for five days of the week, nine months of the year. There are not transferable paradigms and thus there is a persistent attempt to apply old adages in an attempt to ensure survival."[1]

This guidebook is designed to inform teachers who work with young children about the different types of restraint and seclusion (R/S) used in the classroom and their effects on the child's welfare. The guidebook also proposes alternatives to R/S that can support the teacher and improve classroom management, as it has been shown that good class management can reduce and even prevent R/S in school settings.[2]

From the start of their child's enrollment in elementary school, parents already have ideas concerning how their child's teacher should respond to their child and meet their child's needs. Parents assume that their child's teacher will familiarize themselves with their child through classroom observations as well as through carefully implemented strategies to help their child to perform well and to succeed. For their part, teachers' approaches to the children in their classroom are shaped by their pedagogical education. Teachers' training influences their interpretations of their students' behaviors and the strategies they choose to meet the needs of these youngsters.

In some instances, a child's parents and teacher may have contradictory views. For example, given the social and academic demands that schools experience, children may feel the pressure associated with learning to conform to structured time. Parents may understand the need for this transition and expect the school to take time for the child's adjustment. Time pressure and academic requirements constrain quality adjustment for children. While teachers understand the issue of adjustment, they face the demand of organizing transitions around the development of academic expectations. It is necessary to create a system of cooperation where these discrepancies can be addressed collaboratively by both teachers and parents.

Teachers and parents share the common goal of supporting children in their academic and social

[1] McEwan, E. K. (1998). *Angry parents, failing schools: What's wrong with public schools and what you can do about it.* Wheaton, IL: Harold Shaw, quote on 136.
[2] Miller, D. N., George, M. P., & Fogt, J. B. (2005). Establishing and sustaining research-based practice at Centennial School: A descriptive case study of systemic change. *Psychology in the Schools, 42*(5), 553-567.

development.[3] Teachers anticipate that the adjustment periods for their students will vary; however, in some cases, there are students who need extra support and structure to meet the demands of the classroom setting because they present challenging behaviors that impact the whole class. Rose and Gallup write that, "Disruptive behavior in schools has been a source of concern for school systems for many years and, in fact, the single most common request for assistance from teachers is related to behavior and classroom management."[4]

Schools use different mechanisms and strategies to manage students' behaviors. Two of those mechanisms are the use of restraint and seclusion (R/S). A body of research shows that R/S are detrimental to the student and negatively impact those around the student.

Teachers play an important role in organizing a safe community in order to foster a healthy, respectful environment conducive to learning in the classroom. Teachers are required to be diagnosticians, in order to assess their students' progress, and to be advocates for all their students, particularly when the teacher recognizes that a child may need additional support services. When interventions are required to support a child's challenging behavior, teachers are also required to collaborate with other professionals who interact with the child.

In order to promote children's prosocial behavior, prevent disruptive behavior, and reduce the number of incidents of R/S, ongoing collaboration amongst administrators, teachers, parents and support personnel should be implemented.[5] There is a need to acknowledge that some children's behaviors are challenging at home and at school, and these challenging behaviors can be expressed differently, depending on the environment. Children can present with challenging behaviors as a result of being exposed to trauma, having disabilities, experiencing a loss in their family, undergoing a difficult transition or for other reasons, and at those times children need to be able to access how to use prosocial behavior.[6]

[3] Ibid.
[4] Rose, L., & Gallop, A. (2005).The 37th annual Phi Delta Kappa/Gallup poll of the public's attitude toward the public schools. *Phi Delta Kappan, 87*(1), 41-54.

[5] Miller, D. N., George, M. P., & Fogt, J. B. (2005). Establishing and sustaining research-based practice at Centennial School: A descriptive case study of systemic change. *Psychology in the Schools, 42*(5), 553-567.
[6] Greene, R. W. (2008). *Lost at school: Why our kids with behavioral challenges are falling through the cracks and how we can help them*. New York, NY: Scribner.

Section II.
Definitions[7]

- Restraint involves the "forced restriction or immobilization of the child's body or parts of the body" as a consequence of a behavior presented by the child.
- Manual restraint involves applying various "holds" for immobilizing a child or bringing a child to the floor. Holds are *prone* if the restraint holds the child horizontally in a face down position, and *supine* if the restraint holds the child horizontally in a face up position; in both cases, the child will be "kept in the chosen restraint position by one or more staff person's arms, legs, or body weight."
- Mechanical restraint refers to the "use of straps, cuffs, mat and blanket wraps, helmets, and other devices to prevent movement and/or sense perception, often by pinning the child's limbs to a splint, wall, bed, chair, or floor."
- Chemical restraint is "using medication to stop behavior by dulling a child's ability to move and/or think;" excluded are prescribed medications that treat symptoms of a disability or illness.
- Seclusion "involves forced isolation in a room or space from which the child cannot escape. Allowing a child to voluntarily take a break from activities is not considered seclusion."

[7]TASH.(n.d.).*Shouldn't school be safe?: Working together to keep every child safe from restraint and seclusion in school*, quote on iv. Retrieved from http://tash.org/wp-content/uploads/2011/07/TASH_Shouldnt-School-Be-Safe.pdf

Section III.

Adverse Consequences of Restraint and Seclusion and Understanding Emotional Regulation

"Each occurrence of R&S is high risk and nonconsensual, limits freedom of movement, and creates the possibility of severe physical injury and emotional trauma to the child, staff and other children in the setting."[8]

When children are *emotionally regulated*, they are under control and capable of accessing coping mechanisms even when they are under stressful circumstances because they have the ability to recall strategies that worked for them in the past. Examples of such strategies are asking for help, moving away from the stressful circumstance, expressing their frustration with words and/or crying, etc. By employing these coping strategies they are able to return to a normative emotional state with relative ease.

"An emotional state is a constellation of relatively stable repeated patterns of motivational variables and patterns of self-experience characterized by specific forms of activity, cognition, affect and relatedness."[9]

This "constellation" is reflected in how we act, how we think and how we feel. It supports us in our efforts to relate to others. Under stressful conditions this pattern can get deregulated. When we feel unable to cope, the ways we act, think and feel can affect how we relate with others. Students that are not regulated and whose 'constellations" are thrown off course by stressors can be subject to R/S. Because they are in a deregulated state, they may subsequently not be able to recall what happened to them while they were being restrained.[10]

[8]Kennedy & Mohr, as cited by LeBel, J., Nunno, M., Mohr, W., & O'Halloran, R. (2012). Restraint and seclusion use in U.S. school settings: Recommendations from allied treatment disciplines. *American Journal of Orthopsychiatry, 82*(1), quote on 75.

[9]Lichtenberg, Lachman, & Fossage, as cited by Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach.* New York, NY US: Guilford Press, quote on 47.

[10] Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach.* New York, NY US: Guilford Press.

CASE SCENARIOS

Restraint and seclusion affect more than just the child who is being restrained and/or secluded. As mentioned above, these risky procedures may lead to severe physical injury and emotional trauma to the child and others involved in the child's life. Below you will find realistic case scenarios that reflect the multiple ways that restraint and seclusion affect teachers, parents, and students.

Nohorita, a 32-year-old teacher, is frustrated that one of her students is leaving her classroom at the child's parents' request. The principal stated that the parents complained that Nohorita "does not control her classroom well and allows children to be out of control, and as a consequence their child goes home scared and upset." The teacher explains, "I have one student that takes all the attention for an hour or more daily, I need to attend to the child's needs and it takes away my ability to oversee the other 22 children."

Cecilia, a 30-year-old mother, is seriously considering resigning from her job in order to "home-school or do something" to support her five-year-old child, who is coming home sad, angry and confused, and at times with bruises, as the result of being restrained at school. Cecilia addressed her concerns to the principal and explained that quitting her job will put added pressure on a household that is already facing financial difficulties.

Hector, a seven-year-old boy, does not want to go to school. He cries and screams and asks his mother not to take him there. He says, "Mommy, they hit me there, they put me on the floor and they hurt me."

Section IV.

Roots of Challenging Behavior

On a daily basis, teachers must contend with a range of challenging behaviors in the classroom.[11] Children can have difficulty regulating their emotions or difficulty with academics. They may also have difficulty with social interactions, such as participating in a group or negotiating sharing. As a result of any of these complications, students may disrupt the classroom by making threatening gestures, insulting other students and even becoming physically disruptive.

These challenging behaviors may be a consequence of one or more stressors, such as a hidden or diagnosed academic disability, lack of social skills, traumatic experiences, or the death or significant loss of a parental figure. A child may have a mental illness such as ADHD, Autism, Depression, Anxiety, Oppositional/Defiant Disorder or other conditions. Unidentified abuse and neglect may also be the root of the challenging behavior. Lastly, unsafe environments, domestic violence and verbal, physical or sexual abuse contribute to childhood stress.[12]

The document *Helping Traumatized Children Learn,* published in 2005, presents evidence showing that school and family environments that do not recognize or know how to attend to challenging behaviors contribute to the perpetuation or exacerbation of the child's symptoms. For this reason, a collection of resources has been developed to help implement school support for children traumatized by family violence. It is necessary to support all children by the use of literacy interventions, classroom accommodations and specialized instruction, as children respond well to these teaching approaches.[13] Nevertheless, there are few resources available that are designed specifically to guide teachers in being able to optimally help these children.[14]

An important part of this guidebook is to ensure that teachers and parents know about the consequences of using R/S as a classroom management strategy. It is believed that improved knowledge of R/S will lead to reduced use, since research has established that R/S leads to physical

[11] Greene, R. W. (2008). *Lost at school: Why our kids with behavioral challenges are falling through the cracks and how we can help them.* New York, NY: Scribner.
[12] Ibid.

[13] Cole, S. F., O'Brien, J. G., Gadd, M. G., Ristuccia, J., Wallace, D. L., & Gregory, M. (2005).*Helping traumatized children learn: Supportive school environments for children traumatized by family violence.* Boston, MA: Massachusetts Advocates for Children.
[14] Ibid.

and psychological trauma, and possibly severe physical injury or death. The use of restraint and seclusion also affects children, staff and bystanders because it can trigger emotions such as humiliation, fear, loss of control, and anger. The use of restraint and seclusion thus has a profound impact on the quality of relationships. Research has shown that adverse effects of R/S include increased rates of aggression and violence, problematic behavior, lose-lose outcomes for everyone, and abuses.[15]

Our aim is to introduce an alternative approach to classroom management that values children by supporting teachers, parents, staff and administrators. The mental health system and the child welfare system share the same goal and have implemented strategies towards this end. The Massachusetts Department of Mental Health adopted the public health prevention model, a three-tiered prevention model to most effectively improve management of problematic behavior:

- Primary Prevention: preventing the need for R/S
- Secondary prevention: early intervention which focuses on the use of creative, least restrictive alternatives, tailored to the individual, thereby reducing the need for R/S
- Tertiary prevention: reversing or preventing negative consequences when, in an emergency, R/S cannot be avoided

Addressing reduction and prevention of R/S is a collaborative effort that will require systemic changes that will have an impact on workforce development and provide additional supports in the classroom and school based services.

An important step that some schools are taking is to implement positive behavioral supports. For example, problematic behaviors are being redefined as symptoms that communicate a child's distress to those responsible for the child's care. It is then up to the teacher and the administration to design an intervention that can respond to the child's distress in a positive way.

The mental health system has demonstrated success when addressing how to understand trauma-informed care by using systemic strategies, such as the six core strategies: leadership, use of data to inform practice, full inclusion of consumers and families, rigorous debriefing (incident review), workforce development and use of seclusion and restraint prevention tools.[16]

[15] LeBel, J., Nunno, M., Mohr, W., & O'Halloran, R. (2012). Restraint and seclusion use in U.S. school settings: Recommendations from allied treatment disciplines. *American Journal of Orthopsychiatry, 82*(1), 75-86.

[16] National Association of State Mental Health Program Directors. (1999). *Reducing the use of seclusion and restraint: Findings, strategies, and recommendations*. Alexandria, VA: Author.

Section V.

Building upon Teacher's Strengths

It is important to redefine a classroom as an environment that promotes academic and social skills opportunities for all children, and is open to address additional literacy intervention, specialized instruction and classroom accommodations for children who require those services.

This new approach to classroom dynamics should be shared with students so that they can be empowered to contribute to its success. To this end, specific guidelines need to be shared with all students by posting verbal instruction and non-verbal posters to ensure that they fully understand the format within which such a classroom can effectively operate. These are outlined below.

Create a Safe and Respectful Environment

- ✓ Hitting is prohibited.
- ✓ Aggressive physical contact such as spitting, shoving, pushing and scratching is prohibited.
- ✓ Name calling is prohibited.
- ✓ Be respectful of differences among peers.
- ✓ Be mindful of offensive behaviors: avoid insulting, teasing, or making fun of others.

Encourage Organization and Responsibility

- ✓ Maintain an orderly environment: tools such as crayons, pencils, pens, rulers, blocks, markers, toys, etc. are to be kept in place, and should be used appropriately and safely.
- ✓ Everything has a place: coats, backpacks, materials.
- ✓ It is the students' job to keep the classroom clean & orderly; after all it's their learning space and students should take pride in it.

Create an Environment with Clear Guidelines and Structure

- ✓ Everybody helps to create the classroom guidelines; everybody is part of the community.
- ✓ The schedule is posted, and everybody is familiar with what the day will look like.
- ✓ Establish consistent routines so the children know how the morning will go.
- ✓ Every classroom needs to have a special space where children can take a break.

Collaborative Efforts between the Faculty and Other Key Players

- ✓ The teacher builds a relationship with each child.
- ✓ The teacher builds a relationship with parents.
- ✓ The teacher builds relationships with other professionals (occupational therapists, physical therapists, counselors, clinicians and others).

Create an Environment That Will Support the Teacher When Additional Services and Supports are Required

- ✓ Establish a formal or informal peer support group.
- ✓ Request professional development that will support your learning in the areas of disabilities, trauma-based care and stressors that affect children's behavior such as divorce, domestic violence, witnessing a community crisis and other environmental stressors.
- ✓ Review on a regular basis to see if prevention measures are in place, and that they are working.
- ✓ Make adjustments as necessary.

TEACHER AS AN ORGANIZER OF A COMMUNITY OF LEARNING

The teacher plays a vital role as a community learning organizer: educators provide academic instruction to students, and those students bring different levels of experience, learning and abilities in their efforts to process the new material. Teachers accommodate the differences that their students bring to the classroom in order to create and organize a diverse community of learners.

Most children are able to manage the daily expectations of their classroom. These expectations include the demands of the academic work, the morning routine, transitions, and the unstructured times of the day, i.e., lunch and recess. They are able to perform and produce academic requirements at grade level.

Most children are able to sustain positive social interactions with peers and adults. When conflict does happen, most respond appropriately to redirection and problem solving techniques. Once the conflict is resolved, children are usually able to resume their activities and reintegrate into the classroom.

Most children play and interact with each other in a way that demonstrates connection, joy, collaboration and healthy interpersonal relationships.

The following strategies and activities will provide support for those students who are not able to engage so easily in prosocial and self-regulating behaviors:

Prevention Promotes a Positive and Safe Learning Environment

Use positive behavioral interventions and become familiar with the Positive Behavioral Interventions and Supports (PBIS) framework.[17]

- ✓ "A traumatized child who is unable to regulate emotional states needs a social environment that can help the child respond effectively to stressful events."[18]
- ✓ Have a plan in place that includes prevention measures, response to crisis, and the ability to reconnect and rebuild existing relationships with child, peers, family and staff.
- ✓ Promote restraint and seclusion free environments that will diminish the risk of injuries for the child and staff.
- ✓ Promote alternatives to restraint and seclusion, such as conflict management, crisis prevention, de-escalation skills and individualized plans for children.

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[17] OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports. (n.d.). What is school-wide positive behavioral interventions & supports? Retrieved from http://www.pbis.org/school/what_is_swpbs.aspx

[18] Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach*. New York, NY US: Guilford Press, quote on 96.

- ✓ Support the establishment of a coalition with parents, peers, occupational therapists, physical therapists, clinicians and leaders that regularly explore effective mechanisms to make positive changes.
- ✓ Participate in the creation of policies and procedures that support a restraint free environment.
- ✓ Participate in a PBIS framework that will build supports to address challenging behaviors.

You will find a sample intervention list generously provided by a local school in Boston, Massachusetts, the Blackstone Elementary School. Their intervention list shows the tiers of the prevention model as well as internalizers and externalizers that may help you to map your particular school and the services that they provide (Appendix A). PBIS is an approach that supports Positive Behavioral Interventions and Supports in schools. This model initially appeared in the 1997 reauthorization of the **Individuals with Disabilities Education Act** (**IDEA**) and was emphasized in IDEA 04. Furthermore, the U.S. Department of Education's Office of Special Education (OSEP) model made an additional effort to support it by funding a National Technical Assistance Center on PBIS.[19] (http://www.pbis.org/about_us/default.aspx).

TEACHER AS A DIAGNOSTICIAN/ASSESSOR

Teachers might notice how upon their arrival to school, some children are deregulated and unhappy. Their body language might reflect high levels of stress.

[19] LeBel, J., Nunno, M., Mohr, W., & O'Halloran, R. (2012). Restraint and seclusion use in U.S. school settings: Recommendations from allied treatment disciplines. *American Journal of Orthopsychiatry, 82*(1), 75-86.

Teachers might notice if a child is consistently late, or shows other indications of deregulated or unusual behaviors. For example, a student may be consistently tired in the morning or uncooperative after lunch, a student may seem to be hungry, tired or unusually moody. When a teacher suspects deregulated behavior, it is important for that teacher to collect data that will identify patterns, such as noting the time of the day when the child has problems, and identifying whether the problematic behavior is linked to academic or social cues. It will be important for the teacher to identify whether the child responds to more or less structure. It will also be useful to do an informal assessment, for example, by drawing up an academic profile in all areas. It may also be important to conduct a critical analysis of the child's interactions with peers and adults.

You will find that the Department of Mental Health in Massachusetts developed and posted an informational crisis prevention/safety tool (Appendix B). This tool will support you to identify triggers, warning signs, and safety techniques. This resource also provides you with a description of how to use it.

Approaches May Include

- ✓ Assess body language.
- ✓ Observe interactions with peers.
- ✓ Explore body comfort: hunger, tiredness, thirst.
- ✓ Identify if environment is different: social activity, group activity, field trip.
- ✓ Be aware of weather: too cold, too hot, or too humid.
- ✓ Does child look sick? Consult with nurse.
- ✓ Consider whether the sensory environment is overwhelming: loud noise or too many people.

TEACHER AS AN ADVOCATE

Once a teacher has identified that a child needs additional support, the teacher can create a plan that addresses the matter, including the areas that need support, such as social, academic, developmental or family arenas.

The teacher can make accommodations in the classroom setting. Examples of such changes might be modifications in the curriculum, creation of an environment that promotes positive connections, strengthening the teacher-student alliance, behavior modification, and fostering a culture of tolerance and diversity in the classroom that is inclusive.

If a child deregulates and acts out by yelling, pushing, swearing, hitting, or withdrawn behavior and loses control in front of the child's peers, the teacher as an advocate can use this experience as a teachable moment, and explain to other children what happened in a sensitive manner that creates an atmosphere of compassionate support for the particular child and peers involved.

Some Alternatives May Be

- ✓ Explore point sheet levels: Create simple and helpful point sheets, a visual support instrument to help increase on target behavior and to help kids improve performance
- ✓ Individualized sensory break
- ✓ Ask for support for child: social worker or aid.
- ✓ Provide fidget toys.
- ✓ Limit social interactions.
- ✓ Communicate with home and explore solutions.
- ✓ Consider academic modification.

You will find a sample generously provided by a local school in Massachusetts, the Blackstone Elementary School (Appendix C). This sample may help provide information that will help identify students' strengths and assets, as well as any academic, familial or medical concerns and services in place for the student.

TEACHER AS A COLLABORATOR

The teacher knows that additional support is needed for children requiring additional accommodations. The teacher consults with other teachers, occupational therapists, physical therapists, the inclusion facilitator, parents and administrators to design a plan that can support the child.

The teacher may notice that the student requires additional support because the accommodations do not seem to help or are insufficient. The teacher will consult with other teachers, the occupational therapist, the physical therapist, the inclusion facilitator, the parents and/or administrators to explore an additional plan that can support the child.

Once it is clear that further support is needed, it is necessary to pay attention to academics, social skills challenges, behavioral issues and other factors.

If an Individualized Education Program (IEP) is necessary, further evaluations will have to be scheduled. Practical restructuring of the support system, for example communicating with the student verbal cues and nonverbal cues, can serve to protect the connection between the teacher and the student and to preserve the child's ego. Because implementing an IEP takes time, in the meantime, it will be helpful to use ongoing reminders, to identify triggers, and to use responsive classroom techniques.

Helpful Practices for Success Using a Collaborative and Preventive Framework

Work with parents or legal guardians.

- ✓ Ensure youth participation.
- ✓ Use debriefing after each incident.
- ✓ Establish if the R/S is a unique event.
- ✓ Establish if the R/S is a repeated event.
- ✓ Collaborate with OT, PT, MH and outside providers.
- ✓ Attend ongoing trainings.
- ✓ Review policies with administration.
- ✓ Reassess child and youth strengths.
- ✓ Be mindful of the classroom environment.

Putting together a system that will work for all children requires the ability to see each student as separate from the next student. In other words, a universal approach to better environments will be of crucial importance. Also necessary is the ability to identify when there is a need for an individualized support to take place involving a strategy for resolution and a specific management plan. Preventive measures such as these will avoid crisis and provide support for teachers. Having in mind the following strategies and adding the teacher's new innovative activities will support a calm and positive environment for learning.

Strategies

De-Escalation Skills

- Exercise
- Relaxation techniques
- Scheduled breaks
- Meditation
- Yoga
- Breathing exercises
- Attend to hunger, tiredness, fatigue, physiological needs.
- Self-empowerment and positive self-image thoughts and activities
- Outdoor activities
- Working and taking care of pets

Individualized Plans for Children

- ✓ Attend to learning disability.
- ✓ Attend to history of trauma. Teachers are not mental health clinicians; however, if they identify a traumatic history by parents, caretakers or by the child's disclosure, they need to refer the case to the guidance staff, school psychologist, psychiatric nurse and/or community mental health center.
- ✓ Attend to mental illness. At times, the teacher may sense that something is different about a particular child. If the child is unable to succeed with strategies that work for most children, the teacher may need to refer the child to mental health services. It is possible that the mental health staff can identify resources and ways to support a child that may be affected by mental illness.
- ✓ Attend to stressors: divorce, domestic violence, homelessness, and family members that serve in the military.
- ✓ Work collaboratively with the IEP.
- ✓ Work collaboratively with youth and family.

Inclusive Quiet Space

- In the classroom, teachers can create a special place where children can go when needing a break, when frustrated, when sad, or when tired. This friendly space needs to be safe, to have toys that calm their restlessness, positive calming books, and if possible quiet, soothing music. Children are empowered to take a break, to choose an activity and to be respected by peers when in the quiet space. Teachers can explain and model how to use the quiet space. It is important that the space is inclusive, and that children who use this space feel both

safe and connected to the rest of the classroom.

- It is important to create a classroom setting conducive to learning: think of child behavior that is both typical and atypical while organizing your classroom; a child with typical behaviors can be a distraction to a child with ADHD or sensory issues.

Collaborative Approach

- Ongoing work with a collaborative approach involves mindfully gathering parents' input, working with the parent to set joint guidelines, scheduling occupational therapy, mental health and physical therapy interventions and activities.
- Access administrators' and include facilitators' input to create a comprehensive approach that will support the teacher and the student.
- Be aware of any outside stressors taking place in the student's family and environment. Events such as divorce, domestic violence, homelessness, mental illness, pre-deployment, deployment and post-deployment of family members, foster care situations or others will affect the student.
- Good communication and supportive coordination with guidance counselors, school psychologists and others will help the teacher to be mindful. It is well known that changes in the environment will have an impact on the child's behavior, thinking and feelings in the classroom.
- Address student's learning ability with inclusion of parental input, and ensure that all plans are linked with the goals that have been worked out for this student. Thus, strategies including restraint-free IEP, appropriate fostering of emotional regulation, and social and academic skills will be implemented in a way that is appropriate for this student.

You will find a Positive Behavioral Support Plan sample, used with permission from Dr. Ross Greene (Appendix D). The positive behavior support plan is a collaborative approach that supports children that present with challenging behaviors to find alternatives option that enriches the child and the child's environment.

Section VI.
R/S Prevention, Conflict Resolution, Crisis Prevention and De-Escalation

Alternatives to R/S are very important because they will support the physical and psychological safety and wellbeing of the child and others, reduce painful witnessing by surrounding children, increase the morale of staff because of a better and safer job environment, strengthen relationships between teachers, parents and administrators and increase the capacity for effective behavior in children. This section will focus on presenting alternatives for teachers that will encourage the use of classroom management strategies conducive to fostering a social-emotional positive environment, as an activity that supports reducing R/S.

Evidence-Based Practices in Classroom Management[20]

1. **Maximize structure and predictability**
2. **Post, teach, review, and provide feedback on expectations**
3. **Actively engage students in observable ways**
4. **Use a continuum of strategies to acknowledge appropriate behavior, and**
5. **Use a continuum of strategies to respond to inappropriate behavior**

[20]Simonsen, B., Fairbanks, S., Briesch, A., Myers, D., & Sugai, G. (2008). Evidence-based practices in classroom management: Considerations for research to practice. *Education and Treatment of Children, 31*, 351-380.

In order to help children affected by trauma and other conditions to learn, it is necessary to identify and address the relevant barriers in a way that will promote improved performance. For example, instead of viewing trauma as a problem, teachers can have a strengths-based approach. It is also important to avoid blaming the student or the parent, and to acknowledge that staff is affected by these issues and can feel helpless and overwhelmed.

Teachers need to be able to balance the student's needs with the needs of the rest of the class, and it is important for teachers to acknowledge when they do not have the skills to handle a situation.[21, 22] The teacher should provide a structured classroom with clear rules that apply to each classroom environment, including class time, transition time, recess and lunch, as well as any academic or social events.

[21]Saxe, G. N., Ellis, B. H., & Kaplow, J. B. (2007). *Collaborative treatment of traumatized children and teens: The trauma systems therapy approach*. New York, NY US: Guilford Press.

[22]Cole, S. F., O'Brien, J. G., Gadd, M. G., Ristuccia, J., Wallace, D. L., & Gregory, M. (2005). *Helping traumatized children learn: Supportive school environments for children traumatized by family violence*. Boston, MA: Massachusetts Advocates for Children.

Teachers should be mindful that the disability of a child's trauma experience goes with the child elsewhere. A teacher's role in responding to a child's trauma will be different from that of a clinician; however, teachers can contribute to helping the traumatized child by creating a stable and supportive classroom.[23]

Mentoring
Experienced teachers know "tricks of the trade" and can facilitate the new teacher's journey. As well as providing valuable support to new teachers, the healthy relationship between teachers that this kind of mentoring relationship can create has a positive effect on classroom dynamics.

Peers' Support
Active listening and perspective taking from peers may enrich the teachers' viewpoint and provide space for development, insight and skills building.

Pre-Service and Ongoing Training
It is very important that teacher-training courses include education concerning classroom management. Classroom management skills should be further fostered through Continuing Education courses and opportunities to practice skills. Proper classroom management will empower educators to get closer to the goal of a calm environment.[24]

Collaboration
Collaboration with parents, mental health clinicians, occupational therapists, physical therapists and other professionals will ensure that the teacher sees the child as a whole person, and is able to provide additional appropriate supports.

Resource Center and Interactive Learning
Advocate for a place where teachers and parents can access information and share resources conducive to improve the communication and to learn the latest strategies to reduce and prevent R/S in school settings. Creating and sustaining an environment where parents and teachers can learn from each other about what works will promote the goal of a positive environment for development and learning for all.

Explore Your School's Resources
Explore and discuss the attached resources to learn what works in other settings and in other schools.

Work Proactively with your School Administration
Collaborate on the creation, revision and ongoing updates of policies that support reduction and prevention of R/S.

Self-Care
Teachers need to learn to take good care of themselves in order to be able to take care of a roomful of students.

"We are all cognizant of the reality that interpersonal relationships take time to build and nurture. But relationships with students are somehow not viewed through that same lens."[25]

[23] Ibid.
[24] Butchart, R. E., & McEwan, B. (Eds). (1998). *Classroom discipline in American schools: Problems and possibilities for democratic education*. Albany, NY: State University of New York Press.

[25] McEwan, E. K. (1998). *Angry parents, failing schools: What's wrong with public schools and what you can do about it.* Wheaton, IL: Harold Shaw, quote on 136.

Simonsen, Fairbanks, Briesch, Myers, and Sugai presented a report[26] on classroom management, arguing it was a critical area that influenced students' performance. The report was based on an evidence-based approach rather than on available anecdotal literature generated by reports given by successful teachers. The authors developed a systematic literature search to identify evidence-based classroom management. They identified twenty practices and explored how to incorporate them into the classroom. They also developed an assessment tool in order to evaluate and enhance the practices, and they made some suggestions for future research.

Classroom management has three central components, the first is to maximize time for instruction, the second is to provide instructional activities that engage students and support achievement of learning, and the third is the practice of proactive behavioral management.[27] The researchers reviewed recent classroom management texts and created a list of recommended practices that were grouped into five categories: (a) physical arrangement of classroom, (b) structure of classroom environment, (c) instructional management, (d) procedures designed to increase appropriate behavior, and (e) procedures designed to decrease inappropriate behavior.

Closing Statements

If an emergency situation arises, and the need for a R/S intervention is present despite the available considerations for support, the teacher will need to access her/his school policies on handling and debriefing these aversive interventions with the understanding that observing, documenting, informing parents and debriefing will be a positive tool to understand and to avoid repetition of the R/S event. Advocacy effort for strategies that continue to support the reduction and prevention of R/S events need to be in place.

An important document you may explore to understand current statues of R/S in schools is *Shouldn't School Be Safe?* Available at: www.tash.org.

[26]Simonsen, B., Fairbanks, S., Briesch, A., Myers, D., & Sugai, G. (2008). Evidence-based practices in classroom management: Considerations for research to practice. *Education and Treatment of Children, 31*, 351-380.
[27] Ibid.

SECTION VII.
Resources

Assistive Technology
Assistive technology is equipment or services that help children participate in and complete school assignments and activities. Explore The Massachusetts Initiative to Maximize Assistive Technology (www.massmatch.org) and The Federation for Children with Special Needs (www.fcsn.org/index.php). Both websites inform on latest technology.

Helping Traumatized Children Learn
This is a report and policy agenda for supportive school environments for children traumatized by family violence. It explains trauma as the consequence of family and other forms of violence and connects it with the effects of trauma on learning. It helps to make the connection with educational difficulties and supports teachers to understand how and why the students may have difficulties focusing, learning, connecting with others and using proper behavior. The report provides a school-wide flexible framework that supports a public policy agenda for the development of trauma-sensitive school environments where traumatized children and their classmates can focus, behave, and learn. Available from www.massadvocates.org/documents/HTCL_9-09.pdf.

"Restraint and Seclusion Use in U.S. School Settings: Recommendations from Allied Treatment Disciplines" by Janice LeBel, Michael Nunno, Wanda Mohr, and Ronald O'Halloran
This academic article describes what are restraint and seclusion (R/S) procedures, its risks, its history and preventive approaches from other arenas like the mental health and child welfare organizations that will help schools to learn how to understand, reduce and prevent R/S, the authors present a R/S prevention framework that uses core strategies to prevent and reduce use of R/S. Available from the *American Journal of Orthopsychiatry*, Volume 82, Issue 1, pages 75–86, January 2012.

Massachusetts Department of Mental Health Informational Tool
This tool was developed by the Massachusetts Department of Mental Health for children in hospital settings; it was not developed for school settings. However, it provides ways and samples that can help teachers to learn how to identify triggers, understand warning signs and find supports to help their students. It is necessary to see this tool as a sample only, and it is suggested that schools contact the developers to consult on possible adaptations for the school setting. Available from

www.mass.gov/eohhs/docs/dmh/rsri/safety-tool-for-kids-sample.pdf.

***The Compassionate School: A Practical Guide to Educating Abused and Traumatized Children* by Gertrude Morrow**

The author suggests the community and educational system work together to ensure that schools promote social development that fosters respect and acceptance of all students which will foster a cooperative learning environment.

National Association of State Mental Health Program Directors

This website provides several important resources, successful stories and samples that will support school's efforts to reduce R/S. The website provides access to the 2008 Seclusion and Restraint Briefings, the Six Core Strategies to Reduce Seclusion and Restraint Use and additional relevant information concerning the national efforts by NASMHPD to reduce and prevent R/S in psychiatric and other settings. Available from www.nasmhpd.org.

National Disability Rights Network

The National Disability Rights Network continues advocating for the U.S. Department of Education to take a more active role to reduce and prevent the use of restraint and seclusion on school children. Available from www.napas.org.

***Collaborative Treatment of Traumatized Children and Teens: The Trauma Systems Therapy Approach* by Glenn N. Saxe, B. Heidi Ellis, and Julie B. Kaplow**

This book helps teachers, families, clinicians and others to understand traumatized children affected by environmental stressors: poverty, substance abuse, and family or community violence in a system that may be unequipped to respond. Its approach empowers school, families and communities to use evidence-based strategies by accessing their step-by-step guidelines for assessment and intervention.

APPENDIX A.

Tiered Intervention List

(Sample That Uses the PBIS Framework[28])

TIER ONE – UNIVERSAL SUPPORTS:

- ✓ Attendance data wall
- ✓ Attendance incentives and messaging
- ✓ *The Blackstone Way* - Proper posture, Lean forward, And listen, Nod your head, Track the speaker (PLANT), Silent, Straight, and Right (SSR), voice level, hand up- noise off, "I" messages, eyes and hi's, bathroom signal, compliments, hall passes, appreciations, cafeteria expectations
- ✓ Buddy classrooms Open Circle curriculum and meetings
- ✓ Accountable talk structures
- ✓ UBUNTU awards and award ceremonies - School core values – RESPECT, UNITY, EXCELLENCE
  - o The Blackstone Principle, UBUNTU: "A person with Ubuntu is open and available to others, affirming of others, does not feel threatened that others are able and good, for he or she believes in a greater whole and is diminished when others are humiliated or diminished, when others are tortured or repressed." –Desmond Tutu
- ✓ PBIS school wide initiatives – in the hallways, arrival, dismissal, in the classroom, cafeteria, recess
- ✓ City Year corps member in classroom support – grades 3, 4, 5. The City Year corps is a program that encourages young people to support and help in school settings to keep students attending school regularly and to prevent drop outs (www.citycorps.org).
- ✓ Character education classes with Ms. Cooper
- ✓ Play works

TIER TWO:

- ✓ City Year attendance coaching
- ✓ City Year attendance - student focus lists
- ✓ City Year lunch buddies
- ✓ Boston Partners in Education – Power Lunch
- ✓ Big Brother, Big Sister

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[28] OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports. (n.d.). What is school-wide positive behavioral interventions & supports? Retrieved from http://www.pbis.org/school/what_is_swpbs.aspx

- ✓ South End Community Health Center - individual counseling
- ✓ South End Community Health Center – group counseling
- ✓ Generations, Inc. 1:1 mentoring
- ✓ Student Success Team (SST) – *See A. Hart for more information
- ✓ Functional behavior assessment – FBA
- ✓ Student specific behavior modification chart
- ✓ Afterschool program with character education components
- ✓ Coaching and classroom observations
- ✓ Parent/caregiver meetings
- ✓ Cool down classroom

TIER THREE:

- ✓ South End Community Health Center – individual counseling
- ✓ South End Community Health Center – group counseling
- ✓ Functional Behavior Assessment (FBA)
- ✓ Student specific behavior modification chart
- ✓ SST – *See A. Hart for more information
- ✓ City Year attendance – student focus lists
- ✓ Parent/caregiver meetings
- ✓ Individualized Education Program (IEP)

APPENDIX B.

Massachusetts Department of Mental Health Safety Tool[29]

This tool was developed by the Massachusetts Department of Mental Health for children in hospital settings; it was not developed for school settings. However, it provides ways and samples that can help teachers to learn how to identify triggers, understand warning signs and find supports to help their students. It is necessary to see this tool as a sample only, and it is suggested that schools contact the developers to consult on possible adaptations for the school setting.

Suggestions/Guidelines for Using Safety Tools

Descriptions:

- **Triggers tool:** A one page document of pictures and words to help the child recognize triggers or situations that create fear, sadness, anger, etc. The triggers tool is divided into sensory categories to help staff and children identify circumstances that create upset more easily.
- **Warning sign tool:** A one page document of pictures and words to help the child make the "cause and effect" connection between triggers, their reaction to triggers and how the situation physically affects their body.
- **Safety Tool:** A two page document of pictures and words to help the child identify sensory-based calming (coping) tools. Blank spaces are included to add personalized tools not included on the list.

Initial Safety Tool Use:

- Tools should be filled out within the first 24-48 hours of admission.
- Information for the tools should be obtained from the child and their family/people who know the child best; though not necessarily at the same time.
- Safety Tools can be completed in more than one session. Collaborative process: youth-centered, constructed with the family and the teacher.

Important History:

[29] Available from www.mass.gov/eohhs/docs/dmh/rsri/safety-tool-for-kids-sample.pdf

- Understand the child's trauma history to be sure Safety Tool interventions are not re-traumatizing: it is necessary for teacher to work with mental health clinician. For example, has the child been locked in bedrooms or closets; has he/she been abused by specific objects that may invoke re-traumatization.
- Have the child identify the least traumatizing style of containment based on their history. (Face-down, face-up, empty space, cushioned space, etc.)
- Does the child have a history of asthma, a recent fracture or pre-existing medical condition that may be further impacted by the use of restraint or seclusion?

Staff Training:

- Protocols should be in place to train staff on the implementation, integration and communication of the information obtained from the Safety Tools.
- Consistency of terminology must be used for safety/calming tools, treatment plans, coping strategies, etc. so that staff, family and consumers have a similar understanding of what different tools and strategies are and how they are being utilized.

Integration on the unit:

- Provide copies of the Safety Tools to each child
    - Hang copies on the child's room door (with consent of the family and child)
    - Post calming strategies on bulletin boards and highlight skills that are utilized during the day
    - Create laminated pocket size Safety Tool cards for children to carry with them
    - Incorporate personalized Safety Tools on the back of the child's daily schedule

- Revise and update Safety Tools on a frequent basis
    - At the end of the day, have children identify to their "check in person" a Safety Tool strategy that they tried that either worked or did not work
    - Provide time for the Safety Tool information to be reviewed from shift to shift
    - During individual treatment sessions and in collaboration with mental health clinician, assist children with the integration of triggers, warning signs and sensory-based coping skills.

- Groups and program integration
    - Offer groups that incorporate a variety of sensory-based Safety Tools to help calm and organize the child during transitions
    - If your school has an occupational therapist on board, consult with the OT person. He or she will help you to assess sensory needs/deficits and teaching sensory intervention, as OT's are the experts in this domain. If your schools do not have an OT in place, is necessary to inquire how to access and solicit a consultation for assistance in this area.

- Incorporate sensory-based activities after sports or active groups to calm and ground children prior to their next group. It is necessary to use a collaborative approach with the school's OT if possible.
- Provide role-play situations for children to practice using identified Safety Tool strategies
- Provide environments (quiet room, unit, corners, etc.) with sensory-based activities to foster exploration and incorporation of Safety Tool strategies into daily experiences

- Education
  - Educate children about the importance of Safety Tools and the use of the Safety Tool information to assist with calming, grounding and organizing themselves on a day to day basis

    Educate child's family members about the Safety Tool information and how it has been useful to the child. It is necessary to use the collaborative approach with mental health clinician and/or psychiatric nurse who can support the training for families. Educate the treatment team and staff at potential discharge settings about Safety Tool strategies that were useful (and not useful) in helping the child feel safe

- Discharge
  - Promote carryover of the skills the child has learned and used by providing a copy of the Safety Tool to appropriate community-based clinicians working with the child and family
  - Every child should receive a copy of their up to date Safety Tool to take with them upon discharge
  - Parents/guardians should receive an updated copy of the child's Safety Tool
  - If a child is being transferred to another treatment program, a copy of the Safety Tool should be clearly identified and attached to the transfer paperwork.

IDENTIFYING TRIGGERS TOOLS

What makes you feel upset?

(Circle all that make you feel sad, mad, scared or other feelings)

Touch

Being touched

Too many people

See

Darkness

Hear

Loud Noises

Yelling

Thunderstorms

Others

Missing someone

Being left alone

Being surprised

Having a fight with a friend

Being sick

Certain time of year

Certain time of day/night

Having my bedroom door open

Anything else that makes you feel upset? _____

NOTE: The following are general triggers for people

Being told what to do rather than asked;

Being told no rather than being given choices.

WARNING SIGN TOOL

What happens to my body when I am angry, scared or upset?
(Circle all that apply)


Cry


Clench teeth


Loud voice


Red/hot face


Laughing/giggling


Being mean or rude


Swearing


Racing heart


Breating hard


Wringing hands


Clenched fists


Upset stomach


Shaking or tapping


Jumping up and down or stamping feet


Rocking


Hyper


Running or pacing

SAFETY TOOL

What helps you feel better?
(Circle all that help you)

Touch


Writing


Fidget tools


Games


Toys or blocks


Bath or shower


Stress ball or clay


Special blanket or cloth

Any other objects you touch or hold that help you feel better? _____

See


Reading


Watching TV


Looking at pictures


Using a computer

Any other objects you like to look at that help you feel better? _____

Movement


Using a rocking chair


Swinging


Dancing


Sports
(kickball, basketball, soccer, etc.)

Any other movements you like that help you feel better? _____

Hear

Talking on the telephone

Listening to music

Singing or humming

Quiet place

Counting to ten

Do you prefer music that is: □ Loud or □ Soft
What type of music do you prefer: _____
Any other sounds or noises that help you feel better? _____

Pressure touch

Hugging a stuffed animal

Sitting in a bean bag chair

Using a weighted blanket

Climbing on a jungle gym

Exercise

Sitting on a therapy ball

Getting a hug

Any other activities that help you feel better? _____
(Examples: blowing bubbles, deep breathing, etc.)

Smell
Any smells that help you feel better? _____
(Examples: peppermint, popcorn, cookies, flowers, etc.)

Taste
Any certain tastes that help you feel better? _____
(Examples: chewy, crunchy, salty, sour, spicy, etc.)

Are there times that it is important or helpful for you to eat? _____

APPENDIX C.

2011-2012 Blackstone SST Referral

(Sample That Uses the PBIS Framework[30])

Student Name:_____Referring Teacher:_____

Grade:_____ D.O.B:_____/_____/_____Age @ time of referral:_____ yrs._____mo.

What others teachers/staff work with this child?	Parent/Caregiver Information	Parent/Caregiver Information
1.	Name:	Name:
2.	Phone #:	Phone #:
3.	Phone #:	Phone #:
4.	e-mail:	e-mail:

- Language spoken at home: English Spanish Other:_____
- Date of parent/caregiver contact about SST referral:_____/_____/_____
- With whom did you speak?_____What number did you use?_____
- What school did the child previously attend?_____When?_____
- Have you contacted his/her former school/teacher? YES NO
- Has he/she been presented to SST before? YES NO Where?_____

Briefly describe the student's strengths and assets:

_____

_____

_____

_____

[30] Ibid.

Student's strengths and assets: ACADEMIC/BEHAVIORAL/SOCIAL-EMOTIONAL/FAMILY. Check all that apply.

☐ High achievement on tests/quizzes	☐ Hands in homework consistently	☐ Participates in class
☐ Resilient when facing setbacks	☐ Has goals for own future	☐ Motivated to do well
☐ Has clear personal talent/skill	☐ Has positive sense of self	☐ Follows directions
☐ Leadership qualities	☐ Responds to feedback	☐ Is friendly / outgoing
☐ Manages conflicts with peers well	☐ Verbalizes needs appropriately	☐ Creative thinker
☐ Extracurricular sports/clubs	☐ Home/School Partnership	☐ Extended family

☐ Involved in other positive activities (e.g., athletic, creative arts, faith community)

Briefly describe the student's challenges:

_____

_____

_____

_____

Data Snapshot: (AS OF _____/_____/_____) (Write N/A when appropriate.)

- Number of tardies:_____
- Number of absences:_____
- Number of red level infractions:_____
- Number of yellow level infractions:_____
- Number of suspensions:_____
- ELD level:_____(k-5)
- MCAS:_____Math_____ELA (3-5)
- ANET:_____(3-5)
- 2010/11 DIBELS +Rdg. Level:

_____BOY_____MOY_____EOY

- DIBELS:

_____LNF(k)	_____ORF(1-5)
_____ISF(k-1)	_____TRC(k-2)
_____PSF(k-1)	_____F&P(3-5)
_____NWF(1-2)	

- Fluency is: at or above | below | far below benchmark (WPM_____)
- Reading level is: at or above | below | far below benchmark (Level____)
- Math skills are: at or above | below | far below benchmark

From your perspective, what is the reason for this SST referral? Circle all that apply.

Academic | Family
Behavior/Social Emotional | Attendance
Health/Medical | Other:_____

- Best times for someone to observe the student:
  Monday _____-_____, Tuesday _____-_____, Wednesday _____-_____,
  Thursday _____-_____, Friday _____-_____,

PLEASE CIRCLE ALL THAT APPLY

ACADEMIC CONCERNS –

- Grades declining
- Poor reading skills
- Poor writing skills
- Poor math skills
- Disorganized
- Slow rate of work completion
- Does not work independently
- Does not work well with others
- Little retention of new learning
- Does not follow directions
- Gives up easily
- Poor study skills

HEALTH/MEDICAL CONCERNS –

- Body odor/poor hygiene
- Uncoordinated/clumsy
- Evidence of self-mutilation
- Frequent visits to the school nurse
- Complains of nausea or vomiting
- Appears sickly
- Dental issues/poor dental hygiene
- Vision difficulties
- Hearing difficulties
- Health insurance issues
- Agitated/nervous
- On medication _____
- Smells of smoke/alcohol
- Falls asleep in class
- Other:_____

FAMILY CONCERNS –

- Sick caregiver/loved one
- Death of caregiver/loved one
- Unemployed parent/caregiver
- Isolation – limited access to resources
- Language barrier
- Homeless/transient
- Divorce – recent/in process
- Addiction
- Domestic violence
- Other:_____

Please reflect on the following: (Use separate paper if necessary.)

What concerns has the child's parent/caregiver shared with you, if any?

What would you like to see happen for this student?

Is there any anecdotal information that would be helpful to know about this child?

What is in place already?	Date begun	Point person	Comments
TIER TWO + THREE:			
City Year attendance coaching			
City Year attendance – student focus list			
City Year lunch buddies			
Power Lunch			
Big Brother, Big Sister			
SECHC – individual counseling			
SECHC – group counseling			
Generations, Inc. 1:1 mentoring			
Functional Behavioral Assessment - FBA			
Afterschool program			

APPENDIX D.

Positive Behavioral Support Plan[31]

SELF-REGULATION/SELF-MONITORING

When Student shows an inability to self-regulate/evaluate he can demonstrate the following behaviors: "this sucks", talking to others during teacher instruction, not following specific instructions (put your folders away and take a seat)

STAFF REACTION:

Preventative

- Remind Student of the self-regulation/self-monitoring strategies he is working on
- Review his targeted strategies when upset/frustrated
- Positive Practice of self-calming strategies daily (i.e. deep breaths)
- Show him visual break schedule (currently: before math, before dismissal, after snack/recess, and then 2 others that he will ask for as needed)
- Have both mandatory breaks and "as needed" breaks. Mandatory breaks should be scheduled prior to a disregulating/anxiety producing activity (discern this through data).We want to keep his anxiety at a low rate through the day (anxiety is like pain – need to take Tylenol every few hours or pain becomes debilitating – anxiety is the same)

In the Moment

- Label his emotion and point to the visual on the emotional thermometer ("you seem frustrated" tell him how you know: your face is scrunched, you are saying "this is boring")
- Use Alert program metaphor in addition to emotional thermometer ("how's your engine?")
- Do a "body check": Student I am noticing….(list examples of disregulated behavior)
- Coach in vivo. Remind Student that he has strategies for when he's frustrated/upset – point to a visual (this way you're not problem solving for him, but coaching him to find the solution):"you're frustrated. What strategy are you going to use".
    - Deep breath
    - Ask teacher for help
    - Use his words (functional communication)

[31] The Collaborative Approach, used with permission from Dr. Ross Greene (www.livesinthebalance.org)

- Empower him. Remind him he has had success (i.e. remaining calm and following directions) before and that he is capable (give the specific example without too much language)
- Use concise language: too much language may escalate and overwhelm him
- Use anxiety management techniques (keep his anxiety level down: mandatory breaks, as needed breaks, previewing novel or difficult tasks, emotional thermometer ("you're feeling anxious, what can we do), preview novel or difficult tasks first thing in the morning and start the first problem with him (then he won't react with resistance when he is introduced to it later in the day- do this with homework as well)

After

- Label and praise use of self-regulation strategy: "you were able to use a strategy and stay calm", "you were able to go to work in a separate room because you knew it would be hard for you to concentrate".
- Have Student fill out self-rating sheet (see attached)

Curriculum/Methodology

- Michelle Garcia Winner – social thinking lesson sequence
- Cognitive Behavior Theory techniques
- Alert program
- Brain Gym
- ABC data analysis

INCREASING EXECUTIVE FUNCTIONING SKILLS

When Student shows an inability to take perspective he can demonstrate the following behaviors: sits and waits for teacher to approach, "this is boring", "Ugh, what the heck, get out of my way"

STAFF REACTION:

Preventative

- Use a daily visual schedule with time labeled and review it with him in the a.m.
- Use an "oops" board for any unexpected change in schedule
- Present gestalt goal of the lesson/unit when introducing it
- Preview new materials/activities
- Review the components necessary for an novel activity in the following parts: Time, Sequence, Materials Needed, People
    - Example:
        - **Time**: use visual clock/timer, tell him in the amount of time allotted what is expected and then what would be "bonus"
        - **Sequence** (go to the bathroom before fieldtrip)
          Use an individualized schedule or social story– have him sequence it, including smaller steps like bathroom and transitions.
        - **Materials Needed** (notebook, pencil, etc.)
          Outline the supplies he needs, especially for novel activities.
        - **People** (may need teacher to check my work)

In the Moment

- Stop and Read the Room

  Student may have difficulty walking into a room and organizing himself. He "misses" a lot of information, such as everyone is quietly reading so therefore I will walk in quietly and get out my materials as well. Or he may "miss" the directions written on the board and start doing something he likes rather than following directions, even if all the kids are doing the correct thing.

  When Student walks into a room, he should be taught to "read the room" before he enters and "make a plan" as to what the appropriate action will be when he enters.

- Make a Future Picture

  In order to "plan" Student needs to see a visual in the head of what the expectation is. For example, he needs to picture "cleaned up" in art means all the paints are away and on the shelf and the brushes are washed, etc. Student may have incorrect forethought, such as picturing "cleaned up" means lining up holding the picture he made.

  He needs to predict (space, time, objects, and people) and create an accurate forethought. This is why organization during transitions is difficult: he can't foresee the next step accurately.

  - Use Visual Schema Strategy – take a picture of what cleaned up looks like in art and give it to him. Then say, "match the picture", instead of giving him a checklist or a list of verbal prompts.

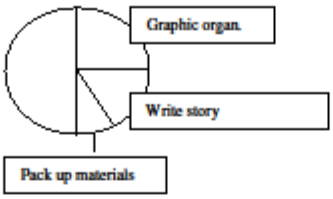
- Label the whole then identify the parts
- Break up tasks into small parts: only present one problem at a time, or modify visual representation of material to less overwhelming
- Rephrase emotional language with the fact

  Ben: "This history book is boring"

  Teacher: "So, historical fiction has lots of details to get through?"

- Use Declarative language: Instead of "pick up your notebook please", say "your notebook – hmmm" (Others:"I've noticed that, how do you know when)
- Use transition warnings: see cognitive flexibility section
- Use organizations tools for writing such as a graphic organizer
- Open-ended writing assignments – use pictures, books, photos to help his initial thought and sustain his thinking about details.

- Use a visual clock with different tasks lay out as to the actual time it SHOULD take.



After

Give him tangible sense of completion: look you've now read 5 out of the 10 books we have this week. (show him graphically)

Curriculum/Methodology

- Cognitive Behavior Therapy techniques
- Executive Functioning techniques (Sarah Ward)
- Child lead "embedded" and explicit instruction

INCREASING COGNITIVE FLEXIBILITY

When Student shows cognitive inflexibility he can demonstrate the following behaviors: "this sucks,""That's not fair…why does he get to…""I'm not reading that." Difficulty with new concept (looks non responsive, unfocused, engaging in alternative behavior),

STAFF REACTION:

Preventative

- Understand he is uncomfortable and something doesn't make sense or has changed without his expecting/understanding it.
- Use declarative language."I notice that….", "Seems like you would like a turn….humph". This will promote his awareness and independent problem solving (instead of giving him directives like "ask for a turn nicely".
- Promote awareness of space, time, objects, and people important in behaving appropriately (i.e. "**read the room**", prior to walking in so he gains information important to act appropriately).
- Provide instruction on flexible thinking explicitly
- Provide support around judging and planning time
- Teach strategies for when he is frustrated: role play, review daily
- Give him controlled choices when needed. Instead of telling him to "get in line". Ask him if he wants to get in the front or the back of the line.
- Avoid yes/no questions when he's escalated. More likely to say "no".
- Provide transition support

- Visual schedules – to be reviewed early (before he has decided on a schedule) – this will help him cognitively shift during transitions
- Transition warnings (give him a concrete "end" to an activity before he starts it, i.e. stop on page 15 or three more minutes), as well as give him a warning about the start of the next activity (5 more minutes)
- Visual representation of time elapsing for non-preferred activities
- Transition sponges: give him a structured task during the "down time" of transitions (while waiting for people to clean up lunch and line up, have him put notices in mailboxes).

In the Moment

- Student will use his emotional thermometer to identify his "gray area" emotions before they get too big (with support) or the Alert program (How does your engine run). He will be assisted to use the corresponding strategies.
- Label his emotion if he doesn't. Student you are frustrated/upset right now what can you do.
- Promote accurate episodic memory in vivo. Rephrase any negative or emotional statements with facts (i.e. "math is boring", rephrase "multiplication requires a lot of memorizing")
- Cue him with metaphors (if he's accepting): he is acting like ROCK BRAIN (describing inflexible thinking from Superflex curriculum) but we are asking him to try to be SUPERFLEX (describing being flexible from Superflex curriculum).
- Give him non-verbal directions with visuals (put a note on his desk that says, "please stop banging your pencil", instead of verbally interacting. Then don't give eye contact and move away. This will prevent him from reacting verbally (arguing).
- Empower him. Remind him he has had success before and that he is capable of being flexible (give him a specific example without too much language)
- Use concise language: Too much language may escalate and overwhelm him.
- Narrate for him what is happening in the moment: "we are having fun-you are laughing", "wow, you finished quickly", "30 minutes goes by fast". This will help him gain an accurate episodic memory of the event (30 minutes isn't the longest period of time on the planet, he doesn't always hate math (he was laughing), he isn't stupid).
- Coach in vivo. Remind Student what his strategies are when he's frustrated/upset:
  - Deep breathing
  - Ask for help
  - Use his words (functional communication)
- Coach him to **Self-talk**
- Use Collaborative Problem Solving language/techniques

Curriculum/Methodology

- Michelle Garcia Winner – social thinking
- Responsive Classroom
- Cognitive Behavior Therapy techniques
- Executive Functioning techniques

- Child lead "embedded" and explicit instruction
- Collaborative Problem-Solving

INCREASING PERSPECTIVE TAKING

When Student shows an inability to take perspective he can demonstrate the following behaviors: "You don't know that.", "You only got three right", Saying answer before other student has chance to answer, "No you are not suppose to shoot it like that." Physically moving peer out of way. Talking over peers during play or group activity.

STAFF REACTION:

Preventative

- Understand that he is misunderstanding/not taking into account the point of view of the other individual/s
- Non-contingent reinforcement- Random acts of kindness toward the student, such as "here is a sticker because I like you" as opposed to "here is a sticker for sitting quietly". Over time, Student will learn to associate the reinforcement with who he is, not what he did (increase self-esteem).
- Use high affect when talking with him
- Use declarative language."I notice that….", "Jimmy can't seem to reach that pencil, humph". This will promote his awareness and independent problem solving.
- "Tempt" him to ask others perspectives."I have an opinion about that…"
- Provide functional communication training "I'm frustrated/confused" and teach alternative strategies: when I'm frustrated I can…
- Rules need to be set prior to playing a game. Student is reminded that one can't change the rules of the game once started.
- Use high affect when talking with him
- Teach explicit social thinking skills: whole body listening, staying on topic in conversation, the need to comment/ask a question to a peer after they have spoken
- Provide explicit perspective taking instruction weekly
- Practice perspective taking with a small group of peers weekly (taking turns in conversation, commenting/asking questions after someone has shared, staying on the topic the speaker has chosen, whole body listening, etc.)

In the Moment

- Label the problem for him."Student we have a miscommunication", or "sounds like Sam is saying he was here first".
- Remind him. Sometimes people think differently than you.
- Cue him with the terms "expected/unexpected". Student your reaction was unexpected….
- Cue him with the terms of "thought bubbles". Student (during the game) Samantha is thinking _____in her thought bubble.

- Promote accurate episodic memory in vivo. Rephrase any negative or emotional statements with facts (i.e. "I hate Miss _____", rephrase "when you are reminded or rules it is frustrating".
- Empower him. Remind him he has had success before and that he is capable (give him specific examples without too much language)
- Use concise language: Too much language may escalate and overwhelm him

After

- Process after the incident with comic strip conversations and the terms "thought bubbles/talking bubbles", expected and unexpected behavior. Literally draw out what happened from a neutral perspective.
- Narrate for him what is happening in the moment: "we are having fun-you are laughing", "Sarah chose you as a partner", "Sam laughed at your joke". This will help him gain an accurate episodic memory of the event (people like him and he has friends).
- Have him fill-out "**Taking Responsibilities of My Actions**" after each incident of inappropriate/unkind comments to peers/adults

Curriculum/Methodology

- Michelle Garcia Winner – social thinking lesson sequence
- Responsive Classroom
- Comic Strip Conversation – Carol Grey
- Social stories – Carol Grey
- Role play
- Thinking maps
- Cognitive Behavior Therapy techniques
- Executive Functioning techniques
- Child lead "embedded" and explicit instruction

APPENDIX B

RECRUITMENT LETTER

Dear _____,

I am writing to ask for your help in recruiting participants for a study that will provide a guidebook for teachers that uses a comprehensive approach to reduce and prevent physical restraints and seclusion (R/S) in public schools. Participants will be asked to provide feedback on the utility of the materials collected and presented, and on their satisfaction with the guidebook more generally. This study is part of my requirements to complete the Doctor of Psychology (Psy.D.) degree at the Massachusetts School of Professional Psychology. Participants will take part in a semi-structured interview, conducted in English, which will last between 30-90 minutes. The names of the participants, as well as all other identifying information and the data gathered in this study will be disguised and kept completely anonymous.

To participate in this study, the participant must be 18 years old or older and participants are teachers. The benefits of providing useful feedback to the guidebook will create a better instrument. A risk associated with this study may be that the participant feels emotional distress on learning of the risks and consequences of R/S. The researcher will provide support and a referral to necessary services if identified by the parties. Participants have the right to withdraw at any time during this study. At the end of the phone or in person interview, participants will receive as an incentive a twenty dollar debit card as appreciation for their participation in this study. If you know anyone who meets the above criteria and who may be willing to participate, please let them know about this study. I am enclosing two notices that you can also distribute among other professionals and individuals consulting your local educational agency.

I will call you within a week to follow up with this letter and inquire about possible participants. The participants are asked to contact me via phone or email. I will also be happy to attend a meeting in your local educational agency to speak about this study and solicit collaboration in the recruitment of participants for this study. If you have any questions or would like to discuss the study with me, please feel free to contact me at (617) 930-2009 or email me at nancy_macias-smith@mspp.edu. I will return your call or email promptly. If you have any concerns or additional questions, you can contact Dr. Stacey Lambert, at 617-327-6777 Ext 288 or at Stacey_Lambert@mspp.edu. She is my doctoral study research advisor.

Thank you in advance for your time in going over these materials and for any assistance you may be able to provide. Should you be interested in the results of this study, I will be very happy to meet with you and your staff upon completion.

Sincerely,

_____

Nancy Macias-Smith, LSW, MMHS, MA
Doctoral Student / Massachusetts School of Professional Psychology

APPENDIX C

INSTRUMENT FOR PHONE CONTACT WITH PARTICIPANTS

Self-identified teachers will call researcher. Information to convey:

1. Identifying Information
2. Schedule the interview Date and time.
    i. When you schedule, ask for a backup time in case the first time slot has to be canceled.
    ii. Try to schedule the interview in a quiet location away from distractions. If participants say they need to find a place outside of their office, the choice of location can be left up to the interviewee's discretion.
    iii. Ask for permission to tape record the interview. Explain that the interviewer would like to stay true to what the participants are saying so that the interviewer does not misrepresent the participant's words. Emphasize that responses will be confidential, the information provided will be added along with that of other people being interviewed to help understand if the created resources can be used to support restraint reduction and prevention in public schools.
    iv. Let the participants know the interview will take approximately 30 to 90 minutes.
    v. Inform participants of the debit card for twenty dollars incentive.
    vi. Provide contact information.

Transcript for phone call:

Thank you for calling. I appreciate your interest in participating in this study. I understand that you are willing to be a participant in my study on a guidebook for teachers aimed to promote the reduction and prevention of restraints in public schools.

I want to thank you for your interest in participating in this study and make sure you know what the study involves. I am a doctoral student in the PsyD program at the Massachusetts School of Professional Psychology. My doctoral project aims to develop a guidebook with the purpose of reducing and preventing the use of physical restraints in public schools in the United States. I created the guidebook to provide information that will support prevention and reduction of physical restraints and my hope is that these resources will improve cultural responsiveness and strengthen the alternative strategies to support non-violent alternatives to manage children's behavior. In the interview, I will ask you questions in order to establish whether the information in the guidebook is useful, if it is easy to digest and if it is pertinent to the stakeholders. I will ask if you are satisfied with the information that is provided in the guidebook and website. I will also ask if there are any ideas that you may want to share related to this topic with me.

I am looking into gathering feedback from teachers who are willing to respond to the question of the usefulness of the guidebook, in particular concerning education on R/S and resource identification. I will also ask if you can respond to the accompanying

subquestion: What are the aspects of this guidebook for teachers that you find most helpful to prevent and reduce the use of restraints in schools?

May I take a few minutes to ask you some brief questions to make sure that your circumstances allow me to invite you to participate? Is that ok?

1. Are you older than 18? and
2. Are you a teacher?

Now tell me, is your answer "yes" to all these questions?

If the answer is "no" to any of the questions:

I am sorry. This means that, unfortunately, I will not be able to interview you, the reason being that I can only interview people who say yes to both these questions. I want to thank you anyway for your interest and wish you the best. Good-bye.

If the answer is "yes" to the questions:

Great! Would you like to set up an appointment for us to meet when it is most convenient for you? I would like for us to meet in a place where you feel safe and comfortable, and where we would have privacy so that you can speak freely. For instance, we could meet at the local educational agency, or in your home. Do you have any suggestions? What day and time would be good for you? Well, we will meet on_____. I would like to make another date in case the first date can't be met. Thanks again for your cooperation and see you soon. Please contact me if there is any change of plans or you need to cancel or reschedule.

Nancy Macias-Smith
Nancy_Macias-Smith@mspp.edu
(617) 930-2009

APPENDIX D

INFORMED CONSENT FORM

I understand I have been asked to participate in a doctoral research study exploring the relevance of a guidebook comprehensive approach for the reduction and prevention of restraints in schools. I understand that this study will be used to help school personnel and families to work together to reduce and prevent physical restraint in public schools.

I understand that I will be interviewed for up to 30-90 minutes and that the interview will be audio-taped and then transcribed.

I understand that everything I say will remain anonymous, and that my name and other identifying data will not be used in any way. I understand that what I say may be used in the research, but that I will remain anonymous and that my identity will not be revealed to anyone but the researcher.

I understand that the results of this study will be used primarily in order to fulfill the doctoral research requirement of Nancy Macias-Smith. However, the results may also be used in later publications by the researcher, without the use of my name or identifying information. I understand my participation is free and voluntary and that I have the right to request a summary of the research findings.

I understand that I am free to participate and can withdraw from this study at any time. If I have any concerns, I understand I can discuss them with the researcher, Nancy Macias-Smith at (617) 930-2009 or at Nancy_Macias-Smith@mspp.edu or her research advisor, Dr. Stacey Lambert. She can be reached at (617) 327-6777 Ext 288 or at Stacey_Lambert@mspp.edu.

The purpose and benefit is to create a useful guidebook as a resource for teachers to reduce R/S and increase the wellbeing of children. I understand that I can refuse to answer any question in this study, and that I can say as much or as little as I wish during the interview. The researcher has been authorized to conduct this study by Dr. Lambert, and the Massachusetts School of Professional Psychology.

I understand that the interview may touch areas that may be emotionally sensitive. The researcher will be personally available to discuss my reactions to the interview and, if I wish, the researcher can refer me back to my therapist at the community health center.

I have read (or had read to me) and understand the details of my participation in this study. I have been given the chance to discuss the study with the researcher. I understand that if I have any questions during the study, they will be answered to my satisfaction. I agree to participate in this study about restraints reduction.

Participant's name: _____ Date: _____
Signature: _____

Researcher's name: _____ Date: _____
Signature: _____

APPENDIX E

INTERVIEW PROTOCOL

Day of interview:

Thank you for agreeing to be interviewed. I am working the Massachusetts School of professional psychology. I am conducting these interviews in order to gather information to help to identify if the created guidebook is useful and to learn from you any additional strategies that can make it stronger.

I would like to remind you that the interview will be recorded so that we can transcribe it and be sure we have captured your answers accurately. This interview is meant to be a conversation, in order to give you a chance to share your experiences and expertise related to physical restraints in public schools.

Your responses will be confidential. We will use the information you provide along with that of other people we are interviewing to help us understand the utility and satisfaction levels of the resources presented to you.

You have the right to terminate the interview at any time if you consider it necessary. Thank you for your participation.

1. Has this guidebook changed your views on R/S? If yes, in what way?
2. What is your overall impression of the guidebook? And what is your opinion on the graphic on the cover?
3. How useful and easy to understand is the information in this resource?
4. Do you think that a resource like this will be useful to other teachers?
5. What level of satisfaction do you have with the product?
6. What additional features do you recommend?
7. What is the best dissemination channel to share related future work?
8. What material is unclear? What will help to clarify it?
9. What material is clear? What strategies are most helpful?
10. Were the case-scenarios helpful for you to digest the information better?
11. What aspects of this resource need improvement?
12. Do you think that a resource like this will be useful to other stakeholders such as clinicians, parents, and administrators? If yes, why?
13. Will you use any of these materials to help other staff understand why it is important to reduce R/S in public schools? If yes, which materials are these?
14. What additional alternatives do you use to handle aggressive behavior?
15. After reading the guidebook, has your viewpoint changed, and do you think that it is an option not to restrain children and if necessary to change school policy? If yes, why? If no, why not?
16. What are your additional strategies for discipline and classroom management?
17. What are the benefits of having a restraint free environment in your classroom? What are the shortcomings, if any, of a restraint free policy? As a teacher do you use physical restraints in your public school setting?
18. How can you handle your own feelings and stress related to the use of R/S in your classroom?

19. Does your school disseminate materials to minority populations related to restraint that are specifically adapted for them and addressed in the language of the affected person? (For example youngsters may be learning English at school and may only be proficient in the language they speak in the home). If yes, which languages?
20. What barriers do you see to implementing a program aimed at reduction and prevention of R/S?
    i. Time not available
    ii. Not sure how to communicate the topic
    iii. School and community are not interested
    iv. Staff are uncomfortable
    v. Negative previous experiences
    vi. Your staff has already discussed the need for this prevention and decided it was not necessary.
    vii. Other, please explain
21. In your experience as a teacher what do you think will help reduce restraints in public schools?
    i. Mental health services
    ii. Occupational therapy
    iii. Social skills groups
    iv. Other _____

Additional Thoughts:

_____
_____
_____
_____
_____
_____
_____

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